



24N
3
3M21

Government
Publicat.

Care



ONTARIO

PROVINCE OF ONTARIO

Commission and Committee of Inquiry

THE MEDICAL SERVICES INSURANCE ENQUIRY

Proceedings of the Public Hearings
held at the Galbraith Building,
University of Toronto,
Toronto, Ontario, at 10:00 a.m.
on Tuesday, January 7th, 1964.

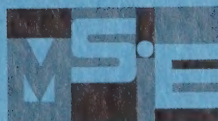
1964

VOLUME

5

DATE

January 7, 1964



VERBATIM REPORTING SERVICE
OFFICIAL REPORTERS
TORONTO, ONTARIO

363 6878

INDEX OF SUBMISSIONS

Page No.

THE SOCIAL PLANNING COUNCIL, METROPOLITAN
TORONTO

347

Appearances: Mr. Harold Lawson, President
Mr. J.F.S. Walmsley
Mr. Ross Dunn, Q.C.
Dr. T. Schofield

THE ONTARIO ASSOCIATION OF SOCIAL WORKERS

381

Appearances: Dr. Elizabeth Govan
Miss Violet Munns
Mr. John Haddad
Mr. Ian Bain

MR. D.K. SUMMERHAYES, DIRECTOR, THE CANADIAN
CYSTIC FIBROSIS FOUNDATION

412

THE ONTARIO PSYCHIATRIC ASSOCIATION

437

Appearances: Dr. R. Chalke
Dr. A. Miller
Dr. H.C. Moorhouse
Dr. J.D. Atcheson
Dr. H.W. Henderson
Dr. K.G. Gray

ASSOCIATED NURSING HOMES INCORPORATED, ONTARIO

501

Appearances: Mr. James E. Fisher
Rev. E. Gill
Mr. George Newbolt
Mrs. Gladys Lauchin



PROVINCE OF ONTARIO

MEDICAL SERVICES INSURANCE ENQUIRY

Proceedings of the Public Hearings
held at the Galbraith Building,
University of Toronto, Toronto,
Ontario, at 10:00 a.m. on Tuesday,
January 7th, 1964.

MEMBERS OF ENQUIRY:

Dr. J. GERALD HAGEY -- Chairman

Mrs. J.A. AYLEN

Dr. WILLIAM BUTT

Miss HELEN CARPENTER

Mr. DALTON J. CASWELL

Mr. A. ROY COULTER

Dr. R.J. GALLOWAY

Dr. JOHN HAMILTON

Mr. W.S. MAJOR

Miss HELEN McARTHUR

Mr. P.J. MULROONEY

Mr. CARMAN A. NAYLOR

Mr. HARRY SIMON

Mr. J.L. WHITNEY

Mr. L.E. TURNER

-- Secretary

PROVINCE OF ONTARIO

MEDICAL SERVICES INSURANCE ENQUIRY

Proceedings of the Public Hearings
held at the Galbraith Building,
University of Toronto, Toronto,
Ontario, at 10:00 a.m. on Tuesday,
January 14th, 1964.

Dr. J. J. Gerald Hagey
Miss Helen Carpenter
Mr. A. Roy Coulter
Dr. R. J. Galloway
Dr. John Hamilton
Mr. W. S. Major
Miss Helen McArthur
Mr. P. J. Mulrooney
Mr. Garman A. Naylor
Mr. Harry Simon
Mr. J. L. Whitney
Mr. L. E. Turner

-- Chairman

-- Secretary

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25



1 --- Upon commencing at 10:00 a.m. SOCIAL PLANNING COUNCIL

2 THE CHAIRMAN: There is a statement which is
3 more or less instruction there on the table. Have you had an
4 opportunity to see those previously?

5 DR. WALMSLEY: Just starting to read them sir.

6 THE CHAIRMAN: Dr. Walmsley you may like to
7 introduce those who are appearing here with you. If so,
8 please feel at liberty to do so. The Social Planning Council of Metropolitan Toronto greatly appreciates
9 this opportunity to present this brief to your Committee today.

10 The members of the Enquiry have read your brief and
11 we would be pleased to hear any further comments that you wish
12 to be considered.

13 DR. WALMSLEY: I am Dr. Walmsley, Chairman of
14 the Health Section of the Social Planning Council of Metro-
15 politan Toronto and Mr. Ross Dunn, who is Vice-Chairman, Board
16 of Directors, of the Social Planning Council. Mr. Lawson is
17 here. He is the Chairman of the Board of Directors of the

18 Social Planning Council and Mrs. Dalman who is a staff member
19 of the Social Planning Council.

20 THE CHAIRMAN: It is not necessary for you to
21 stand up. Just make yourself comfortable there and feel free
22 to proceed.

23 DR. WALMSLEY: One more member here sir. Dr.
24 Schofield, who is a member of the Health Section of the Social
25 Planning Council of Metropolitan Toronto.



1 --- Upon commencing at 10:00 a.m.

2 THE CHAIRMAN: There is a statement which is

3 more or less instruction there on the table. Have you had an

4 opportunity to see those previously?

5 DR. WAINSWORTH: Just starting to read them sir.

6 THE CHAIRMAN: Dr. Wainsworthy you may like to

7 introduce those who are appearing here with you. If so,

8 please feel at liberty to do so.

9 The members of the Endury have read your brief and

10 we would be pleased to hear any further comments that you wish

11 to be considered.

12 DR. WAINSWORTH: I am Dr. Wainsworthy, Chairman of

13 the Health Section of the Social Planning Council of Metro-

14 politan Toronto and Mr. Ross Dunn, who is Vice-Chairman Board

15 of Directors, of the Social Planning Council. Mr. Lawson is

16 here. He is the Chairman of the Board of Directors of the

17 Social Planning Council and Mrs. Dalman who is a staff member

18 of the Social Planning Council.

19 THE CHAIRMAN: It is not necessary for you to

20 stand up. Just make yourself comfortable there and feel free

21 to proceed.

22 DR. WAINSWORTH: One more member here sir. Dr.

23 Schofield, who is a member of the Health Section of the Social

24 Planning Council of Metropolitan Toronto.



1 This has been BRIEF SUBMITTED BY THE SOCIAL PLANNING COUNCIL Mr.
2 Secretary of the Enquiry METROPOLITAN TORONTO addition which he is

3 Appearances: Mr. Harold Lawson, President,
4 Mr. J.F.S. Walmsley,
5 Mr. Ross Dunn, Q.C., replacement. This
6 Dr. T. Schofield.

7 DR. WALMSLEY: Mr. Chairman, members of the
8 Medical Insurance Service Enquiry, the Committee of the Social
9 Planning Council of Metropolitan Toronto greatly appreciates
10 under recommendations in regard to this exemption, we have
11 this opportunity to present this brief to your Committee today.
12 changed the reading. "It is recommended that care should be

13 The Special Committee that was set up by the
14 taken in the implementation of the Medical Service Insurance
15 Social Planning Council to examine the proposed Medical Service
16 Act to assure that there is no detrimental effect on existing
17 Insurance Act examined not only the contents of the Act, but
18 public services." We have changed this to read that there is
19 also examined it from the point of view of what is not included
20 no detrimental effect on existing health services available to
21 in the Act. The review, of course, was also limited by the
22 fact that the regulations under the Act were not available for
23 study. Because of the brief nature of our brief, Mr.

24 Chairman, it had been our original plan to read it through,
25 There are two or three additions and changes
26 as it took some twelve minutes and then to be available for
27 to the brief that was submitted to you sir in November. I
28 questioning but I do see from your statement that this is not
29 would like to call your attention to them at this time, if I
30 required and we can go ahead and reemphasize certain items, if
31 may. In the introduction and summary under item 4 it was
32 you wish, or if you wish to place your questions at this time---
33 pointed out that in error we had called it the Ontario Hospital
34 Insurance Act Bill 165. It is corrected to Ontario Hospital
35 members of the Enquiry who have questions to ask and I think
36 Services Commission Act.

37 probably you will find from some of the questions that you will
38 In the brief itself, on page 4 under item 12
39 be asked that they have studied the brief and unless you have
40 there is a five line remark on article three of the exemptions.
41 something to add to it, I do not think it will be necessary to



BRIEF SUBMITTED BY THE SOCIAL PLANNING COUNCIL

METROPOLITAN TORONTO

Appearances: Mr. Harold Lawson, President,
Mr. J.F.S. Wainman,
Mr. Ross Dunn, Q.C.,
Dr. T. Schofield.

DR. WAINMAN: Mr. Chairman, members of the

Medical Insurance Service Inquiry, the Committee of the Social

Planning Council of Metropolitan Toronto greatly appreciates

this opportunity to present this brief to your Committee today.

The Special Committee that was set up by the

Social Planning Council to examine the proposed Medical Service

Insurance Act examined not only the contents of the Act, but

also examined it from the point of view of what is not included

in the Act. The review, of course, was also limited by the

fact that the regulations under the Act were not available for

study.

There are two or three additions and changes

to the brief that was submitted to you sir in November. I

would like to call your attention to them at this time, if I

may. In the introduction and summary under item 4 it was

pointed out that in error we had called it the Ontario Hospital

Insurance Act Bill 165. It is corrected to Ontario Hospital

Services Commission Act.

In the brief itself, on page 4 under item 12

there is a five line remark on article three of the exemptions.



1 This has been expanded slightly and we have delivered to Mr.
2 Secretary of the Enquiry copies of this addition which he is
3 handing out at this time.

4 THE CHAIRMAN: It is not a replacement. This
5 is an addition?

6 DR. WALMSLEY: This is an addition to those
7 remarks, yes. I beg your indulgence further sir. Item 13
8 under recommendations in regard to this exemption, we have
9 changed the reading. "It is recommended that care should be
10 taken in the implementation of the Medical Service Insurance
11 Act to assure that there is no detrimental effect on existing
12 public services." We have changed this to read that there is
13 no detrimental effect on existing health services available to
14 the public.

15 Because of the brief nature of our brief, Mr.
16 Chairman, it had been our original plan to read it through,
17 as it took some twelve minutes and then to be available for
18 questioning but I do see from your statement that this is not
19 required and we can go ahead and reemphasize certain items, if
20 you wish, or if you wish to place your questions at this time---

21 THE CHAIRMAN: I know that there are several
22 members of the Enquiry who have questions to ask and I think
23 probably you will find from some of the questions that you will
24 be asked that they have studied the brief and unless you have
25 something to add to it, I do not think it will be necessary to



1 This has been expanded slightly and we have delivered to Mr.
2 Secretary of the Enquiry copies of this addition which he is
3 handing out at this time.

4 THE CHAIRMAN: It is not a replacement. This
5 is an addition?

6 DR. WAINMAN: This is an addition to those
7 remarks, yes. I beg your indulgence further sir. Item 13
8 under recommendations in regard to this exemption, we have
9 changed the reading. "It is recommended that care should be
10 taken in the implementation of the Medical Service Insurance
11 Act to assure that there is no detrimental effect on existing
12 public services." We have changed this to read that there is
13 no detrimental effect on existing health services available to
14 the public.

15 Because of the brief nature of our brief, Mr.
16 Chairman, it had been our original plan to read it through,
17 as it took some twelve minutes and then to be available for
18 questioning but I do see from your statement that this is not
19 required and we can go ahead and re-emphasize certain items.

20 THE CHAIRMAN: I know that there are several
21 members of the Enquiry who have questions to ask and I think
22 probably you will find from some of the questions that you will
23 be asked that they have studied the brief and unless you have
24 something to add to it, I do not think it will be necessary to



1 take the time to read it. Is that satisfactory to you?

2 DR. WALMSLEY: Fine sir.

3 THE CHAIRMAN: Mrs. Aylen?

4 MRS. AYLEN: Thank you Mr. Chairman. I have a
5 few questions I would like to ask and the first one is at the
6 bottom of page 3, item 11 you recommend that article one of the
7 exemptions which excludes annual or periodic health examination
8 be deleted. What, in your opinion, could a periodic health
9 examination consist of? How extensive do you think it should
10 be?

11 DR. WALMSLEY: I think it should be as extensive
12 as reasonable for a well-trained family physician to carry out,
13 with certain limited laboratory facilities available to him.
14 This is not the sort of thing that you are thinking about, that
15 someone enters hospital for two days. This must be carried out
16 all throughout the Province. This sort of examination that is
17 carried out at the present time in many departments of industry
18 and other areas generally involves approximately forty-five
19 minutes to an hour of the physician's time.

20 MRS. AYLEN: In the case of not having the
21 facility to carry on this diagnostic procedure, do you think
22 that would prevent people from getting the proper diagnosis?

23 DR. WALMSLEY: I think this certainly is a
24 restriction.

25 MRS. AYLEN: Thank you very much. On page five,



take the time to read it. Is that satisfactory to you?

DR. WALMSLEY: Fine sir.

MRS. AYLEN: Thank you Mr. Chairman. I have a

few questions I would like to ask and the first one is at the bottom of page 3, item 1, you recommend that article one of the exemptions which excludes annual or periodic health examination be deleted. What, in your opinion, could a periodic health

examination consist of? How extensive do you think it should

be?

DR. WALMSLEY: I think it should be as extensive

as reasonable for a well-trained family physician to carry out.

With certain limited laboratory facilities available to him.

This is not the sort of thing that you are thinking about, that

someone enters hospital for two days. This must be carried out

all throughout the Province. This sort of examination that is

carried out at the present time in many departments of industry

and other areas generally involves approximately forty-five

minutes to an hour of the physician's time.

MRS. AYLEN: In the case of not having the

facility to carry on this diagnostic procedure, do you think

that would prevent people from getting the proper diagnosis?

DR. WALMSLEY: I think this certainly is a

restriction.

MRS. AYLEN: Thank you very much. On page five.



1 the item on home care you say here that "The experimental
2 home care programme in Toronto has demonstrated the worth of
3 such a programme and pointed out a widespread need for this
4 type of care." Now do you think this would be difficult to
5 control? How would you suggest that this plan be organized?
6 Through hospitals or through another agency?

7 DR. WALMSLEY: Well this is something that would
8 need to be worked out. I think that presently the one carried
9 out in Toronto is in Toronto City itself and has been set up
10 and supervised by a Special Committee. The cases for early
11 discharge and home care have been reviewed by the two hospitals
12 involved in the study, and there have been available, of course,
13 agency workers and social workers as well. Certainly the
14 services they would need -- they would need to be serviced by
15 visiting home nursing personnel. Visiting home nursing
16 personnel would have to be available.

17 MRS. AYLEN: Do you think this would be possible
18 in smaller communities?

19 DR. WALMSLEY: I think it would be researched
20 in the way it could be carried out. There may be a limitation
21 but certainly we were able to establish health units permanently,
22 full time qualified personnel throughout the Province which
23 extends into all areas, and I feel that this certainly could
24 be investigated and ways and means to carry out such a programme
25 in a rural area could be researched perhaps through the existing



1 the item on home care you say here that "The experimental
2 such a programme and pointed out a widespread need for this
3 type of care." Now do you think this would be difficult to
4 controls? How would you suggest that this plan be organized?
5 Through hospitals or through another agency?

6 DR. WALMSLEY: Well this is something that would
7 out in Toronto is in Toronto City itself and has been set up
8 and supervised by a Special Committee. The cases for early
9 discharge and home care have been reviewed by the two hospitals
10 involved in the study, and there have been available, of course
11 agency workers and social workers as well. Certainly the
12 services they would need -- they would need to be serviced by
13 visiting home nursing personnel. Visiting home nursing
14 personnel would have to be available.

15 MRS. AVEN: Do you think this would be possible
16 in smaller communities?

17 DR. WALMSLEY: I think it would be researched
18 in the way it could be carried out. There may be a limitation
19 but certainly we were able to establish health units permanently
20 be investigated and ways and means to carry out such a programme



1 health units.

2 MRS. AYLEN: Do you feel that under this bill
3 that this could be feasible?

4 DR. WALMSLEY: I think that this is something
5 that should be considered when such a bill is drawn up.

6 MRS. AYLEN: Mr. Chairman, I have a few other
7 questions but I believe some of the other members have questions
8 to ask, so I think perhaps I will wait. Thank you very much.

9 THE CHAIRMAN: Dr. Butt?

10 DR. BUTT: Just following this question which
11 has been asked on the home care, I think our hospital initiated
12 home care, in Mount Sinai and Toronto Western Hospital. These
13 are the two you are referring to. Is that correct?

14 DR. WALMSLEY: Yes.

15 DR. BUTT: And they started when? In September
16 1961?

17 DR. WALMSLEY: Yes.

18 DR. BUTT: Can you give us any more details on
19 whether you feel this rightly comes under the O.H.S.C., the Ontario
20 Hospital Services Commission Act or should include the proposed
21 bill 163?

22 DR. WALMSLEY: Probably should come under the
23 Ontario Hospital Services Act but that would have to be thought
24 about when the Medical Services Insurance Act was finally drawn
25 up because of the question of personnel involved and service



health units.

MRS. AYLMER: Do you feel that under this bill

that this could be feasible?

DR. WAINSBURY: I think that this is something

that should be considered when such a bill is drawn up.

MRS. AYLMER: Mr. Chairman, I have a few other

to ask, so I think perhaps I will wait. Thank you very much.

THE CHAIRMAN: Dr. Butt?

DR. BUTT: Just following this question which

has been asked on the home care, I think our hospital finished

home care, in Mount Sinai and Toronto Western Hospital. These

are the two you are referring to. Is that correct?

DR. BUTT: And they started when? In September

DR. BUTT: Can you give us any more details on

whether you feel this rightly comes under the O.H.S.C. the Ontario

Hospital Services Commission Act or should include the proposed

DR. WAINSBURY: Probably should come under the

Ontario Hospital Services Act but that would have to be brought

about when the Medical Services Insurance Act was finally drawn

up because of the question of personnel involved and service



1 rendered by them.

2 DR. BUTT: Well the Physician Services under
3 163 are covered for those cases in which they are visiting the
4 people in the home.

5 DR. WALMSLEY: That is right.

6 DR. BUTT: I don't think there is any question
7 about that so that really what you want is an extension of these
8 services, nursing home care, and so on?

9 DR. WALMSLEY: That is right.

10 DR. BUTT: You feel this would be a help, as
11 I read your article, the same as it had been outlined but this
12 still comes under O.H.S.C.? Is that not part of their plan?

13 DR. WALMSLEY: Yes, it does, but still there are
14 personnel that may be left. These are professional health
15 personnel, visiting nurses and so on.

16 DR. BUTT: You feel then that Bill 163 does
17 cover visiting nurses, and so forth. Is this what I am to
18 gather?

19 DR. WALMSLEY: It does not at the present time,
20 no sir.

21 DR. BUTT: But you would like it to be?

22 DR. WALMSLEY: I think that these people should
23 be considered once a bill is drawn up because of the increase
24 on their services.

25 DR. BUTT: You feel that this visiting personnel

rendered by them.

DR. BUTT: Well the Physician Services under
163 are covered for those cases in which they are visiting the
people in the home.

DR. WAINWRIGHT: That is right.

about that so that really what you want is an extension of these
services, nursing home care, and so on?

DR. WAINWRIGHT: That is right.

DR. BUTT: You feel this would be a help, as
I read your article, the same as it had been outlined but this
still comes under O.H.S.C.? Is that not part of their plan?

DR. WAINWRIGHT: Yes, it does, but still there are
personnel that may be left. These are professional health
personnel, visiting nurses and so on.

DR. BUTT: You feel that Bill 163 does
cover visiting nurses, and so forth. Is this what I am to

DR. WAINWRIGHT: It does not at the present time.

DR. BUTT: But you would like it to be?

DR. WAINWRIGHT: I think that these people should

be considered once a bill is drawn up because of the increase

on their services.

DR. BUTT: You feel that this visiting personnel



1 should rather be under Bill 163 than the O.H.S.C.? I am trying
2 to figure out just whether we can---

3 DR. WALMSLEY: I don't think it really matters
4 sir. I think we are concerned that they are out, not in.

5 DR. BUTT: That such a thing is covered. Fine.
6 I think that is the main one I have on that point. Then you
7 say: "...to assure that it guarantees the actual cost of
8 services purchased from voluntary organizations." Now that is
9 at the top of page 6 and has to do with the strengthening of
10 the voluntary health movement. If it is a voluntary health
11 organization are you talking about Government participation in
12 this particular field or what?

13 DR. WALMSLEY: Yes. For instance, in the visiting
14 nursing service, if I might amplify on that sir, I might quote
15 from our Needs and Resources of the Social Planning Council,
16 page 122: "In the last ten years, despite the marked
17 increases in Metropolitan Toronto's population,
18 there has been a reduction in the number of nurses
19 employed by the visiting nursing agencies, due to
20 a shortage of funds. In this period the number of
21 persons with chronic illnesses requiring long-term
22 nursing care have increased. The medical home care
23 program, recommended in the section on Health
24 Services, and the present policy of early discharge
25 of patients from hospital further increase the



1 should rather be under Bill 163 than the O.H.S.C.? I am trying

2 to figure out just whether we can---

3 DR. WATKINS: I don't think it really matters

4 sir. I think we are concerned that they are out, not in.

5 DR. BURT: That such a thing is covered. Fine.

6 I think that is the main one I have on that point. Then you

7 say: "...to assure that it guarantees the actual cost of

8 services purchased from voluntary organizations." Now that is

9 at the top of page 6 and has to do with the strengthening of

10 the voluntary health movement. If it is a voluntary health

11 organization are you talking about Government participation in

12 this particular field or what?

13 DR. WATKINS: Yes. For instance, in the visiting

14 nursing service, if I might amplify on that sir, I might quote

15 from our Needs and Resources of the Social Planning Council.

16 page 122: "In the last ten years, despite the marked

17 increases in Metropolitan Toronto's population,

18 there has been a reduction in the number of nurses

19 employed by the visiting nursing agencies, due to

20 a shortage of funds. In this period the number of

21 persons with chronic illnesses requiring long-term

22 nursing care have increased. The medical home care

23 program, recommended in the action on Health

24 services, and the present policy of early discharge

25 of patients from hospital further increase the



1 demand for service. This gives greater urgency
2 to implementing enabling legislation for govern-
3 ment support in all municipalities in Metropolit-
4 an Toronto. Recruitment of professional staff is
5 a constant problem in this service as in other
6 fields.

7 Visiting nurses services are currently
8 being provided in some municipalities of Metro-
9 politan Toronto under The Homemakers and Nurses
10 Services Act. The services of a nurse may be
11 furnished under this Act on the basis of home
12 visits to a person who is elderly, handicapped,
13 ill, or convalescent, where a physician certifies
14 that such services are necessary to enable the
15 person to remain in his own home or to make possible
16 his return to his home from a hospital or other
17 institution.

18 The provincial regulations permit a munic-
19 ipality to purchase nursing services from a volun-
20 tary agency. The Province will reimburse the
21 municipality for 50 per cent of the net cost not
22 exceeding \$1.25 a visit. Patients' fees are based
23 on ability to pay. The municipalities implementing
24 this section of the Act have matched the provincial
25 payments. The total government payments



demand for services. This gives greater urgency
 to implementing enabling legislation for govern-
 ment support in all health services in hospitals
 and Toronto. Recruitment of professional staff is
 a constant problem in this service as in other
 services.
 The Metropolitan Toronto Home Care Services Act
 being provided in some municipalities of Metro-
 politan Toronto under The Home Care Services and Nurses
 Services Act. The services of a nurse may be
 furnished under this Act on the basis of home
 visits to a person who is elderly, handicapped,
 ill, or convalescent, where a physician certifies
 that such services are necessary to enable the
 person to remain in his own home or to make possible
 his return to his home from a hospital or other
 institution.
 The provincial regulations permit a munic-
 ipality to purchase nursing services from a volun-
 tary agency. The Province will reimburse the
 municipality for 50 per cent of the net cost not
 exceeding \$1.25 a visit. Patients' fees are based
 on ability to pay. The municipalities implementing
 this section of the Act have matched the provincial
 payments. The total government payments



1 are substantially lower than the actual cost
2 of service. "

3 DR. BUTT: Your last statement the total Govern-
4 ment payments are less than the actual costs?

5 DR. WALMSLEY: That is right.

6 DR. BUTT: And there are two organizations?
7 Elizabeth, V.O.N. What about the Public Health Nurse?

8 DR. WALMSLEY: They are not included in there.
9 Under Municipal Government money they are fully taken care of.

10 DR. BUTT: And you are not referring to the other
11 things such as the Cancer Foundation, and so on?

12 DR. WALMSLEY: No, except that they are providing
13 a service and that they are filling a need that is there at
14 the present time.

15 DR. BUTT: Yes, I appreciate that they are. I
16 am just trying to differentiate as to how you feel we should
17 attack or help it. The next thing comes under information
18 centres which follows on page 6 and you say these be established
19 on a regional basis. You have one in Metropolitan Toronto I
20 believe?

21 DR. WALMSLEY: There is one at the Social Planning
22 Council.

23 DR. BUTT: Are there any others that you know of?

24 DR. WALMSLEY: Not that I know of.

25 DR. BUTT: But you are suggesting that we try to



are substantially lower than the actual cost

of service.

DR. WAINSBURY:

ment payments are less than the actual costs?

DR. WAINSBURY: That is right.

DR. BUTT: And there are two organizations?

Elizabeth, V.O.N. and the other one.

DR. WAINSBURY: They are not included in there.

Under Municipal Government money they are fully taken care of.

DR. BUTT: And you are not referring to the other

things such as the Cancer Foundation, and so on?

DR. WAINSBURY: No, except that they are providing

a service and that they are filling a need that is there at

DR. BUTT: Yes, I appreciate that they are. I

am just trying to differentiate as to how you feel we should

attack or help it.

centres which follows on page 6 and you say these be established

on a regional basis. You have one in Metropolitan Toronto I

DR. WAINSBURY: There is one at the Social Planning

Council.

DR. BUTT: Are there any others that you know of?

DR. WAINSBURY: Not that I know of.

DR. BUTT: But you are suggesting that we try to



1 establish---

2 DR. WALMSLEY: We feel that a need would be there,
3 yes, because of the great deal of ignorance and lack of
4 knowledge of what is available.

5 THE CHAIRMAN: In view of some of these questions
6 that have been asked, if you wish later to submit a specific
7 recommendation as to how you think the bill might be altered,
8 you are at liberty to do so.

9 DR. WALMSLEY: Thank you sir.

10 DR. BUTT: And then on page 7 you recommend that
11 a pilot study should be developed in order to determine the
12 best way of providing dental care to the institutionalized,
13 homebound and low income people. Should this really be under
14 the Dental Association or do you feel this is part of this Bill?

15 DR. WALMSLEY: I think that we feel that this
16 should be under the Dental Authorities to investigate this
17 and any recommendations that they can make.

18 THE CHAIRMAN: Mr. Mulrooney?

19 MR. MULROONEY: Your recommendation, pursuing the
20 same idea on home care, I wonder do the Social Planning Council
21 of Metropolitan Toronto have estimates of the number of people
22 who are homebound or who need this type of care?

23 DR. WALMSLEY: We can provide that figure for you
24 sir. We cannot give it at the moment.

25 MR. MULROONEY: And you would not have any



1 established
2 DR. WALMSLEY: We feel that a need would be there
3 yes, because of the great deal of ignorance and lack of
4
5 THE CHAIRMAN: In view of some of these questions
6 that have been asked, if you wish later to submit a specific
7 recommendation as to how you think the bill might be altered,
8 you are at liberty to do so.
9 DR. WALMSLEY: Thank you sir.
10 DR. BUTT: And then on page 7 you recommend that
11 a pilot study should be developed in order to determine the
12 best way of providing dental care to the institutionalized,
13 homebound and low income people. Should this really be under
14 the Dental Association or do you feel this is part of this Bill?
15 DR. WALMSLEY: I think that we feel that this
16 should be under the Dental Authorities to investigate this
17 and any recommendations that they can make.
18
19 MR. MILLROONEY: Your recommendation, pursuing the
20 same idea on home care, I wonder do the Social Planning Council
21 of Metropolitan Toronto have estimates of the number of people
22 who are homebound or who need this type of care?
23 DR. WALMSLEY: We can provide that figure for you
24 sir. we cannot give it at the moment.
25 MR. MILLROONEY: And you would not have any



1 estimates of what the cost would be involved in this type of
2 service?

3 DR. WALMSLEY: We can refer to some costs in
4 view of the present study that took place at the recent Home
5 Care Program -- that is taking place in Metropolitan Toronto,
6 in the City of Toronto and which, of course, was a research
7 program which was controlled and therefore limited in the
8 number of people who were so treated but they have an idea of
9 cost per case and an idea of per case saving of hospital time.

10 MR. MULROONEY: You are concerned, I take it
11 from your brief, mainly with the payment, the finding of funds
12 to pay for the paramedical profession rather than the medical
13 men themselves?

14 DR. WALMSLEY: That is right, because they have
15 been covered.

16 MR. MULROONEY: I think that is the information
17 I wanted Mr. Chairman. I think we can get it all.

18 THE CHAIRMAN: Mr. Simon?

19 MR. SIMON: Yes Mr. Chairman. On page 4, item
20 13 you say that care should be taken in the implementation of
21 the Medical Services Insurance Act to assure that there is no
22 detrimental effect on existing public services. Would you
23 care to elaborate on that?

24 DR. WALMSLEY: Yes. This was the recommendation.
25 We had made an addition, further explanation of what we ought

DR. WAINSBURY: We can refer to some costs in view of the present study that took place at the recent Home Care Program -- that is taking place in Metropolitan Toronto, in the City of Toronto and which, of course, was a research program which was controlled and therefore limited in the number of people who were so treated but they have an idea of cost per case and an idea of per case saving of hospital time.

MR. MURPHY: You are concerned, I take it from your brief, mainly with the payment, the finding of funds to pay for the paramedical profession rather than the medical men themselves?

DR. WAINSBURY: That is right, because they have been covered.

MR. MURPHY: I think that is the information I wanted Mr. Chairman. I think we can get it all.

THE CHAIRMAN: Mr. Murphy?

MR. MURPHY: Yes Mr. Chairman. On page 4, item 13 you say that some should be taken in the implementation of the Medical Services Insurance Act to assure that there is no detrimental effect on existing public services. Would you

care to elaborate on that?

DR. WAINSBURY: Yes. This was the recommendation. We had made an addition, further explanation of what we ought



1 to put under Article 3, which is quite a listing of exemptions,
2 some of which have more meaning than others really and some of
3 which are quite obvious as the laboratory and other diagnostic
4 procedures rendered as hospital services to the extent that
5 these are provided for under the plan of hospital care insurance
6 under the Hospital Services Commission Act. This is quite
7 obvious but there are other things there that we felt perhaps
8 should be carefully assessed before they were included in
9 exemptions and the effect that this might have on the total
10 effect under the Act. As we stated here a number of these
11 exemptions, for example, nursing services, drugs, dental
12 services, appliances, put distinct limitations on the kind of
13 care offered and could limit the full benefits of the Medical
14 Services Insurance Act and the Ontario Hospital Insurance Act
15 from being realized in certain instances.

16 We go on to point out that you can provide these
17 in the material and services exemption outside of the hospital,
18 drugs, vaccines, etcetera, special appliances, may create real
19 problems for certain income groups especially in certain areas
20 of the Province. Service exemptions: The exemptions listed
21 need careful consideration regarding progressive enlargement
22 rather than restriction. For example, home nursing services,
23 physical therapy, outpatient, oxygen in the home, etcetera,
24 and outpatient laboratory and diagnostic services, whether
25 Government, commercial or hospital.

to put under Article 3, which is quite a listing of exemptions, some of which have more meaning than others really and some of which are quite obvious as the laboratory and other diagnostic procedures rendered as hospital services to the extent that these are provided for under the plan of hospital care insurance under the Hospital Services Commission Act. This is quite obvious but there are other things there that we felt perhaps should be carefully assessed before they were included in exemptions and the effect that this might have on the total effect under the Act. As we stated here a number of these exemptions, for example, nursing services, drugs, dental services, appliances, but distinct limitations on the kind of care offered and could limit the full benefits of the Medical Services Insurance Act and the Ontario Hospital Insurance Act from being realized in certain instances.

We go on to point out that you can provide these in the material and services exemption outside of the hospital, drugs, vaccines, obstetrics, special appliances, may create real problems for certain income groups especially in certain areas of the Province. Service exemptions: The exemptions listed rather than restriction. For example, home nursing services, physical therapy, outpatient, oxygen in the home, etcetera, and outpatient laboratory and diagnostic services, whether



1 If the Act increases the demand on family
2 physician and consultant services, then the above services will
3 in turn be put under great pressure. Some income groups may
4 find it more feasible to attend a local physician rather than
5 attending a more distant hospital outpatient department.
6 Limitations in Article 3 could limit the local physician's full
7 effectiveness. Many gaps are now present in the above services
8 as witness the attempts by various voluntary groups to supply
9 some of these services. For example prothesis appliances,
10 physical therapy and rehabilitation procedures.

11 It was felt that the question might be an
12 interpretation of some of these exemptions and that we are
13 concerned whether we in turn would perhaps even limit some
14 of the things that are available today under our Outpatient
15 Department Hospital Services. For instance certain public
16 health services, mental health clinic services and so forth
17 because of the limitation of the exemptions that have been
18 put in Schedule A.

19 MR. SIMON: On page 2 in the preamble to your
20 brief you state, under (f): "The assurance that every resident
21 of Ontario may participate in a standard minimum plan without
22 regard to age, state of health or ability to pay." Now I
23 note that mainly your organization has been concerned with
24 the income of groups, and so on, and social planning and I
25 have noticed some figures recently where you publicly stated

If the Act increases the demand on family

physician and consultant services, then the above services will

in turn be put under great pressure. Some income groups may

find it more feasible to attend a local physician rather than

attending a more distant hospital outpatient department.

limitations in Article 3 could limit the local physician's full

effectiveness. Many gaps are now present in the above services

as witness the attempts by various voluntary groups to supply

physical therapy and rehabilitation procedures.

It was felt that the question might be an

interpretation of some of these exemptions and that we are

concerned whether we in turn would perhaps even limit some

of the things that are available today under our Outpatient

Department Hospital Services. For instance certain public

health services, mental health clinic services and so forth

because of the limitation of the exemptions that have been

MR. SIMON: On page 2 in the preamble to your

brief you state, under (f): "The assurance that every resident

of Ontario may participate in a standard minimum plan without

regard to age, state of health or ability to pay." Now I

would like to know that mainly your organization has been concerned with

the income of groups, and so on, and social planning and I

have noticed some figures recently where you publicly stated



1 that the average family in Toronto, the income required for
2 decent living is somewhere around \$5400.00 a year. This
3 includes a quarter of the income from the wife working.

4 Bill 163 states that the Government is going to
5 subsidize certain groups in the community, in the Province.
6 Would you care to elaborate or have you any recommendations
7 with regard to these groups which you feel -- where should the
8 borderline be? Which groups do deserve the subsidy for their
9 medical insurance?

10 DR. WALMSLEY: As far as what is income in
11 groups, and size, I could not be prepared to say right now sir
12 but we could obtain that and make a statement on that, if you
13 wish.

14 MR. SIMON: I would expect it from an organization
15 such as yours anyway.

16 THE CHAIRMAN: We would be expecting that then
17 from you later.

18 DR. WALMSLEY: Very well sir.

19 THE CHAIRMAN: Anything further Mr. Simon?

20 MR. SIMON: No, thank you.

21 THE CHAIRMAN: Mr. Major?

22 MR. MAJOR: Thank you Mr. Chairman. Dr. Walmsley
23 back on page 2 again, article 5: "The Social Planning Council
24 endorses prepaid Health Insurance..." Now prepaid Health
25 Insurance contemplates that the citizens want to pay some of



decent living is somewhere around \$2400.00 a year. This

includes a quarter of the income from the wife working.

Bill 103 states that the Government is going to

subsidize certain groups in the community, in the Province.

Would you care to elaborate or have you any recommendations

borderline? Which groups do deserve the subsidy for their

medical insurance?

DR. WATKINS: As far as what is income in

but we could obtain that and make a statement on that. If you

MR. SIMON: I would expect it from an organization

such as yours anyway.

THE CHAIRMAN: We would be expecting that from

from your letter.

DR. WATKINS: Very well sir.

THE CHAIRMAN: Anything further Mr. Simon?

MR. SIMON: No, thank you.

back on page 2 again, article 5: "The Social Planning Council

endorses prepaid health insurance..." Now prepaid health



1 the cost, if not all. Under (d) and (f) you set forth
2 certain standards and you are stating that this policy should
3 be guaranteed renewable. Now you lock the doors of your house
4 and take the keys of your car. You then admit that there is
5 a certain number of people in this world that you cannot trust.
6 Are you prepared, as a citizen, to pay part of this cost even
7 though a number of citizens may be abusing, grossly abusing
8 the privilege given under a guaranteed renewable agreement,
9 or should there be a stop gap for them?

10 DR. WALMSLEY: I don't think so from what I
11 have seen. I think from my own personal experience in some
12 industries that have very generous programs that the abuse is
13 very little and it is all through careful clinical assessment
14 that we are able to do and follow up. My own feelings are
15 that there are groups that will abuse it, yes, but I think it
16 is a very small proportion of the total population of this
17 province that will be enrolled.

18 MR. MAJOR: Dr. Walmsley, we have laws against
19 felonies and so on. The number of people that commit them are
20 very small. If you are willing to accept a plain statement from
21 a novice in a prepaid health insurance plan ten per cent of
22 the population, be it lay or professional, are not honest. Do
23 you think it is reasonable to put in some kind of law for this
24 ten per cent? If ten per cent of the public were to do pre-
25 meditated murder would you do away with the murder laws just



the cost, if not also. Under (b) and (c) you ask for
certain standards and you are stating that this policy should
be guaranteed renewable. Now you lock the doors of your house
and take the keys of your car. You then admit that there is
a certain number of people in this world that you cannot trust.
Are you prepared, as a citizen, to pay part of this cost even
though a number of citizens may be abusing, grossly abusing
the privilege given under a guaranteed renewable agreement,
or should there be a stop gap for them?

DR. WALMSLEY: I don't think so from what I

have seen. I think from my own personal experience in some
industries that have very generous programs that the abuse is
very little and it is all through careful clinical assessment
that we are able to do and follow up. My own feelings are
that there are groups that will abuse it, yes, but I think it
is a very small proportion of the total population of this
province that will be enrolled.

MR. MAYOR: Dr. Walmsley, we have laws against
felonies and so on. The number of people that commit them are
very small. If you are willing to accept a plain statement from
a novice in a prepaid health insurance plan ten per cent of
the population, be it lay or professional, are not honest. Do
you think it is reasonable to put in some kind of law for this
ten per cent? If ten per cent of the public were to do pre-



1 because it is ten per cent?

2 DR. WALMSLEY: I don't think that is a fair
3 question, Mr. Major. I think what we are discussing here is
4 the question of prepaying and spreading out the medical cost
5 of medical care in this Province. I think if it is ten per cent
6 you are going to have to have a double bill, the physician
7 co-operating with the patient. I am not so sure this happens
8 very often. Yes, there are people who may be overtreated, but
9 it is not so much a crime as there is the problem with ability
10 to treat at the present time. Certainly treating someone for
11 twenty visits, fifteen minutes each and tranquilizers for acute
12 anxiety and reactive depression may not be right, but it is
13 some therapy. This is where I think most of your problems
14 arise in any of these schemes, abuse in this way, rather than
15 in direct planning to abuse them. I think this is so because
16 of the fact that we have limitations, certainly in facilities
17 for therapy and in the ability that we have to carry out certain
18 forms of treatment.

19 MR. MAJOR: Well, Dr. Walmsley, this is an
20 important matter to this inquiry because at some time we are
21 going to have to make definite recommendations. In view of
22 what you said regarding Article 3 and the questions that have
23 been asked about this I gather you are in favour of comprehen-
24 sive health services and not just physician services. By and
25 large the business approach to this type of business is on a



1 because it is ten per cent?

DR. WAINMAN: I don't think that is a fair

question, Mr. Major. I think what we are discussing here is

the question of prepaying and spreading out the medical cost

2 of medical care in this Province. I think if it is ten per cent

you are going to have to have a double bill, the physician

3 co-operating with the patient. I am not aware this happens

4 very often. Yes, there are people who may be overreached, but

5 it is not so much a crime as there is the problem with ability

6 to treat at the present time. Certainly treating someone for

7 twenty visits, fifteen minutes each and transmitters for acute

8 anxiety and reactive depression may not be right, but it is

9 some therapy. This is where I think most of your problems

10 arise in any of these schemes, abuse in this way, rather than

11 in direct planning to abuse them. I think this is so because

12 forms of treatment.

MR. MAJOR: Well, Dr. Wainman, this is an

13 what you said regarding Article 3 and the question that have

14 been asked about this I gather you are in favour of commensurate

15 give health services and not just physician services. By and



1 trust basis and the only place that somebody gets into this
2 Act is for a physician to certify something. If you broaden
3 this out so that nobody, no Committee would have any powers of
4 discretion in respect of the small percentage of people that would
5 abuse them, this is liable to snowball because of abuse. Do
6 you consider the whole gamut of health services....

7 THE CHAIRMAN: Mr. Major, if I may interrupt,
8 am I not right, Dr. Walmsley has expressed the view that Council
9 are in favour of this without limitation. Is that not the
10 answer for which you are looking on this?

11 MR. MAJOR: In view of the one two three four
12 points down to (f) in my opinion the guaranteed renewable
13 clause in insurance is a good clause providing they would have
14 something to say about it. In other words this isn't necessarily
15 setting forth co-insurance, not necessarily setting forth a
16 limitation on the privilege. The compulsion is on the carrier,
17 the privilege is on the citizen, the part of the citizen. What
18 I am looking for here is is it agreed by the public body in
19 this statute that the citizen should not have any discretionary
20 organization should he fall off the beaten path? That is what
21 I am looking for, Mr. Chairman, because this either has to be
22 put or it doesn't have to be put into the Act.

23 MR. LAWSON: Mr. Chairman, Dr. Walmsley looked
24 at the matter, I think from the point of view of the medical
25 men. He is, perhaps, unaware that the point of view of the



Act is for a physician to certify something. If you broaden this out so that nobody, no Committee would have any powers of discretion in respect of the small percentage of people that would abuse them, this is liable to abuse because of abuse. Do you consider the whole grant of health services...

MR. CHAIRMAN: Mr. Mayor, if I may interrupt,

am I not right, Dr. Walmaley has expressed the view that Committee are in favour of this without limitation. Is that not the answer for which you are looking on this?

MR. MAYOR: In view of the one two three four

points down to (1) in my opinion the guaranteed renewable

clause in insurance is a good clause providing they would have

something to say about it. In other words this isn't necessarily

setting forth co-insurance, not necessarily setting forth a

limitation on the privilege. The complication is on the other

the privilege is on the citizen, the part of the citizen. What

I am looking for here is it agreed by the public body in

this statute that the citizen should not have any discretionary

organization should be left off the beaten path. That is what

MR. LAWSON: Mr. Chairman, Dr. Walmaley looked



1 carrier may be somewhat different. We are not so concerned
2 with the doctor who may offer services as with the patient who
3 will visit, the few who will go to 28 different doctors for
4 services within a period of a few months. We get this kind of
5 thing. Some restrictions on wide abuse seem to be necessary.
6 That is, I think, what Mr. Major is suggesting should be
7 incorporated in legislation of this kind.

8 MR. MAJOR: Let us go on then, Mr. Chairman. I
9 think the general consensus of opinion is that the Act as
10 presently outlined is a beginning. Now, if we go down to
11 Article 3 where you are suggesting there should be an opening
12 up of this to include home nursing services, physical therapy
13 drugs etcetera, etcetera -- in the opinion of your organization
14 would you be prepared at the present time to have a launching
15 platform for the health services as suggested for this Act?
16 Do you think it is sufficient for the present time?

17 DR. WALMSLEY: We know you have to walk before
18 you run. I think this has got to go one step at a time. I
19 think the Act should be well aware by solving certain dilemmas
20 it is going to create others and it must be well aware of these
21 and face them and, perhaps, research them. This is an answer
22 to your previous question as well. I think we know that abuses
23 may well happen in certain instances and certainly you have to
24 have certain checks. It is impossible to foresee that until
25 you are giving the service.

center may be somewhat different. We are not so concerned with the doctor who may offer services as with the patient who will visit, the few who will go to 28 different doctors for services within a period of a few months. We get this kind of thing. Some restrictions on wide abuse seem to be necessary. That is, I think, what Mr. Norton is suggesting should be

incorporated in legislation of this kind.

MR. WATKINS: Let us go on then, Mr. Chairman.

I think the general consensus of opinion is that the Act as presently outlined is a beginning. Now, if we go down to Article 3 where you are suggesting there should be an opening up of this to include home nursing services, physical therapy, drugs, etcetera, etcetera -- in the opinion of your organization would you be prepared at the present time to have a launching platform for the health services as suggested for this Act? Do you think it is sufficient for the present time?

MR. WATKINS: We know you have to wait before

you run. I think this has got to go one step at a time. I think the Act should be well aware by solving certain difficulties it is going to create others and it must be well aware of these and face them and, perhaps, research them. This is an answer to your previous question as well. I think we know that abuses



1 MR. MAJOR: Yes, I agree with that. You agree
2 we have to start some place?

3 DR. WALMSLEY: That is correct, sir.

4 MR. MAJOR: Article 3 be amended from time to
5 time as we may amend it.

6 DR. WALMSLEY: That is correct.

7 MR. MAJOR: The annual periodic health examination
8 -- are you acquainted with the studies that have been recently
9 done on periodic health examinations?

10 DR. WALMSLEY: I haven't read that recent report.

11 MR. MAJOR: There have been some notes and
12 studies done by the Department of Hygiene, I think it is, or
13 the University of Toronto and by and large scientifically after
14 a great number of patients have been considered in this, the
15 general consensus of opinion seems to be now in the scientific
16 area, not down in the lay area, that periodic health examinations,
17 per se, are not worth their cost. That is a statement, but
18 coming down to Article 1 in your paragraph 10 "important
19 procedures of preventive and rehabilitative care". Rehabilita-
20 tive care surmises something wrong now, doesn't it, so that
21 you really don't need the physical or periodic health examina-
22 tion to keep this patient under control or to see if there are
23 any changes coming about.

24 DR. WALMSLEY: That is probably true, yes. There
25 is something you may pick up as you go on that would require



MR. MAJOR: Yes, I agree with that. You agree

we have to start some place?

DR. WALMSLEY: That is correct, sir.

MR. MAJOR: Article 3 be amended from time to

time as we may amend it.

DR. WALMSLEY: That is correct.

MR. MAJOR: The annual periodic health examination

-- are you acquainted with the studies that have been recently

done on periodic health examinations?

DR. WALMSLEY: I haven't read that recent report.

MR. MAJOR: There have been some notes and

studies done by the Department of Hygiene, I think it is, or

the University of Toronto and by and large scientifically after

a great number of patients have been considered in this, the

general consensus of opinion seems to be now in the scientific

area, not down in the lay area, that periodic health examination

are not worth their cost. That is a statement, but

coming down to Article 1 in your paragraph 10 "important

procedures of preventive and rehabilitative care". Rehabilitation

five care assumes something wrong now, doesn't it, so that

you really don't need the physical or periodic health examina-

tion to keep this patient under control or to see if there are

any changes coming about.

DR. WALMSLEY: That is probably true, yes. There

is something you may pick up as you go on that would require



1 therapy.

2 MR. MAJOR: What about well-baby care; the periodic
3 check in well-baby care? Would you do this over a period of
4 certain years to take up all the children in society? Would
5 this be sufficient to keep him going in society or her going
6 in society? The current system is to go to the family physician.
7 Would this not be a periodic check, normal care?

8 DR. WALMSLEY: In a sense some are, but there
9 are gaps, however. Very few have had any sort of assessment
10 beyond age of two or three. They exist through the school
11 service. We think they get a form of assessment, health
12 assessment, again perhaps in High School. These, of course,
13 are of little value as an examination in itself. There are
14 many defects you will pick up, but the counselling comes with
15 the examination and the need for follow up, to see that they
16 are going to make these changes in the health status I think
17 are very important. Certainly if you are going to do an
18 ordinary physical examination, do a fairish one about twenty
19 minutes, and check off certain complaints, I feel too this
20 is probably a waste of time. This causes a physician who is
21 very busy, if he can this, have a chance to see his patients,
22 he will find out what he is doing and what is happening as far
23 as health is concerned, to be able to counsel him. That is how
24 defects are picked up. Certainly they are present.

25 MR. MAJOR: Your periodic health examination,



therapy.

MR. MAJOR: What about well-baby care; the period

check in well-baby care? Would you do this over a period of
certain years to take up all the children in society? Would
this be sufficient to keep him going in society or not going
in society? The current system is to go to the family physician
Would this not be a periodic check, normal care?

DR. WAINSWORTH: In a sense some are, but there
are gaps, however. Very few have had any sort of assessment
beyond age of two or three. They exist through the school
service. We think they get a form of assessment, health
assessment, again perhaps in High School. These, of course,
are of little value as an examination in itself. There are
many defects you will pick up, but the counseling comes with
the examination and the need for follow up, to see that they
are going to make these changes in the health status I think
are very important. Certainly if you are going to do an
ordinary physical examination, do a fairish one about twenty
minutes, and check off certain complaints, I feel too this
is probably a waste of time. This causes a physician who is
very busy, if he can this, have a chance to see his patients,
he will find out what he is doing and what is happening as far
as health is concerned, to be able to counsel him. That is how
defects are picked up. Certainly they are present.

MR. MAJOR: Your periodic health examination,



1 would it go so far as gastro-intestinal test series, electro-
2 cardiographs, basic metabolism tests and so on?

3 DR. WALMSLEY: I think this is not what we have
4 in mind. This is where you have in mind certain definite
5 difficulties they are going to require further investigation.

6 MR. MAJOR: In other words milestones of average
7 physical examinations.

8 DR. WALMSLEY: That is right.

9 MR. MAJOR: The examinations you are considering
10 would be forty-five minute propositions?

11 DR. WALMSLEY: I think so.

12 MR. MAJOR: And would carry a fee of perhaps
13 \$25.00 to \$35.00.

14 DR. WALMSLEY: Not necessarily, no.

15 MR. MAJOR: On a time basis?

16 DR. WALMSLEY: No, I think that they could be
17 done for less than that.

18 MR. MAJOR: Thank you.

19 DR. WALMSLEY: Industry pays less than that to
20 have it done.

21 MR. MAJOR: They pay a lot more too, sometimes.

22 DR. WALMSLEY: They may in some cases.

23 THE CHAIRMAN: Mr. Major, Dr. Butt has a question
24 of Dr. Walmsley.

25 DR. BUTT: There are two approaches to this. One, the most



cardiographs, basic metabolism tests and so on?

DR. WALMSLEY: I think this is not what we have

in mind. This is where you have in mind certain definite

difficulties they are going to require further investigation.

MR. MAJOR: In other words mistakes of average

physical examinations.

DR. WALMSLEY: That is right.

MR. MAJOR: The examinations you are considering

MR. MAJOR: And would carry a fee of perhaps

\$25.00 to \$35.00.

DR. WALMSLEY: Not necessarily, no.

MR. MAJOR: On a time basis?

DR. WALMSLEY: No, I think that they could be

done for less than that.

MR. MAJOR: Thank you.

DR. WALMSLEY: Industry pays less than that to

MR. MAJOR: They pay a lot more too, sometimes.

DR. WALMSLEY: They may in some cases.

THE CHAIRMAN: Mr. Major, Dr. Butt has a question



1 accurate the one the School of Hygiene on preventive studies.
2 I believe their statisticians weren't as happy with the overall
3 picture of annual health examinations and it brought out unless
4 there was some complaint, that is the patient goes to the
5 family doctor because something is bothering him -- it may only
6 be anxiety. There is that distinction. What happens in
7 industry and I personally was with one of the most expensive
8 annual health examinations which were done for Fords, Ford
9 Hospital and each fellow came in and it spread out for three
10 days. We did everything, literally. I followed at times a
11 series of a number of smaller companies within Toronto.
12 We did relatively short examinations which were really for the
13 value of the company. I think this is the area, I think it is
14 value for the company and value for the patient. I think the
15 two things, perhaps, the value of annual health examinations
16 with regard to industry, with regard to a big company, to invest-
17 ment in the individual is one thing but to put this in our
18 Bill as a mandatory situation is not really, exactly, medical
19 care and I think there is perhaps a shade of difference. If
20 you can change my view please do so.

21 DR. WALMSLEY: I think you certainly don't need
22 three day examinations. We have found, certainly, in companies
23 I have been associated with on reviewing these there are many
24 things that are past that the statistician may not be very
25 happy about, that is he is not over concerned in that these



accountants the one the School of Hygiene on preventive studies.
I believe their statisticians weren't as happy with the overall
picture of annual health examinations and it brought out unless
there was some complaint, that is the patient goes to the
family doctor because something is bothering him -- it may only
be anxiety. There is that distinction. What happens in
industry and I personally was with one of the most expensive
annual health examinations which were done for Ford, Ford
Hospital and each fellow came in and it spread out for three
days. We did everything, literally. I followed at times a
series of a number of smaller companies within Toronto.
We did relatively more examinations which were really for the
value of the company. I think this is the area, I think it is
value for the company and value for the patient. I think the
two things, perhaps, the value of annual health examinations
with regard to industry with regard to a big company to invest-
ment in the individual is one thing but to put this in our
Bill as a mandatory situation is not really, exactly, medical
care and I think there is perhaps a shade of difference. If
you can change my view please do so.
DR. WAINWRIGHT: I think you certainly don't need
three day examinations. We have found, certainly, in companies
I have been associated with on reviewing these there are many
things that are past that the statistician may not be very
happy about, that is he is not over concerned in that these



1 are easily analyzed. Certainly we are concerned about the
2 problem of weight and weight is one of the things that can be
3 dealt with at this time, for instance. To get back again to
4 the examinations done in industry, they are done for the
5 purpose of the employee in the sense his total health --
6 industry's most important asset is the trained employee because
7 the machinery is changing every year. This is a good thing for
8 the employee. It is done for the purpose of the employee, to
9 keep this employee well. I think the other thing is that if
10 these are not for people who are working and have it made
11 available to them, I think it should be done voluntarily as
12 they are in any industry. They are made available on a voluntary
13 basis for these and it is open to him whether he shall have
14 this examination.

15 DR. BUTT: To be a little more specific, it is
16 mandatory when the individual joins the company.

17 DR. WALMSLEY: They make it mandatory. It is
18 for preplacing health.

19 DR. BUTT: Subsequently they are voluntary.
20 This is fine. In the private practice the point is the patient
21 could avail himself and it is voluntary, but he will usually
22 come with some complaint. You say they should be mandatory.
23 If you are going to get annual health examinations you are
24 going to have to carry it with some almost mandatory reason.

25 DR. WALMSLEY: I think they should be made

are easily analyzed. Certainly we are concerned about the problem of weight and weight is one of the things that can be dealt with at this time, for instance. To get back again to the examinations done in industry, they are done for the purpose of the employee in the sense his total health -- industry's most important asset is the trained employee because the machinery is changing every year. This is a good thing for the employee. It is done for the purpose of the employee, to keep this employee well. I think the other thing is that if there are not for people who are working and have it made available to them, I think it should be done voluntarily as they are in any industry. They are made available as a voluntary basis for these and it is open to him whether he shall have this examination.

MR. BUTT: To be a little more specific, it is

mandatory when the individual joins the company.

DR. WAINWRIGHT: They make it mandatory. It is

for preserving health.

DR. BUTT: Subsequently they are voluntary.

This is fine. In the private practice the point is the patient could avail himself and it is voluntary, but he will usually come with some complaint. You say they should be mandatory. If you are going to get annual health examinations you are going to have to carry it with some almost mandatory reason.

DR. WAINWRIGHT: I think they should be made



1 available. I think the number who will have the check annually
2 will not be great because we simply don't have the facilities
3 to examine them all. If the physician could put a little time
4 to do this -- I think the check could be a certain period and
5 I would feel that it should be of such a nature in the
6 statute that it is differentiated from the visit because of a
7 complaint.

8 DR. BUTT: There is another case where the
9 insurance companies I believe did offer this type of purely
10 voluntary thing and they dropped it because it wasn't used.
11 I believe this is correct. Some insurance company people
12 could probably recognize this. This is the problem with the
13 annual thing. The same problem would be if everybody were
14 looked at, we have six and a half million people at forty-five
15 minutes.

16 THE CHAIRMAN: What the Council has suggested
17 here is this be on a voluntary basis, be available.

18 DR. WALMSLEY: Certainly. I don't think it would
19 ever ruin the doctors' time because we haven't got to that
20 stage yet of regarding the looking after ourselves in this
21 manner. It is not the acceptable thing yet by our society
22 and certainly it will never hurt your insurance rate either.
23 I don't think that because of this it should be left out of
24 the Act.

25 THE CHAIRMAN: What you would like to see is that

1 available. I think the number who will have the check annually
 2 will not be great because we simply don't have the facilities
 3 to examine them all. If the physician could put a little time
 4 to do this -- I think the check could be a certain period and
 5 I would feel that it should be of such a nature in the
 6 statute that it is differentiated from the visit because of a
 7 complaint.

8 DR. HOLT: There is another case where the

9 insurance companies I believe did offer this type of purely
 10 voluntary thing and they dropped it because it wasn't used.
 11 I believe this is correct. Some insurance company people
 12 could probably recognize this. This is the problem with the
 13 annual thing. The same problem would be if everybody were
 14 looked at, we have six and a half million people at forty-five
 15 minutes.

16 THE CHAIRMAN: What the Council has suggested

17 here is this be on a voluntary basis, be available.

18 DR. WAINWRIGHT: Certainly. I don't think it would

19 ever ruin the doctors' time because we haven't got to that
 20 stage yet of regarding the looking after ourselves in this
 21 manner. It is not the acceptable thing yet by our society
 22 and certainly it will never hurt your insurance rate either.
 23 I don't think that because of this it should be left out of

24 the Act.

25 THE CHAIRMAN: What you would like to see is that



1 individual item removed from the exemptions?

2 DR. WALMSLEY: That is right.

3 THE CHAIRMAN: Do you wish to carry on, Mr.
4 Major?

5 MR. MAJOR: I could carry on with this subject
6 for some time, Mr. Chairman. What I was trying to get here
7 was whether or not there was a cloudy interpretation by either
8 you or us. In my view any citizen who has a symptom, there is
9 no reason why they should not go to the doctor. With the
10 motivation of the periodic health examination, when there is
11 an individual of 50 years of age who is absolutely healthy
12 then we don't feel we should give him well adult care. If
13 anybody has any symptom, regardless of how slight it is, then
14 he has got a periodic health examination -- he is going to the
15 doctor and the health services usually pay for it on first
16 dollar coverage. There is a tremendous argument in principle
17 between people who have no symptoms and allowing people being
18 motivated with symptoms on the first dollar basis because they
19 can walk in and the coverage gives them the privilege of having
20 a check-up, but they have to have a symptom for their motivation.
21 It is a matter of distinction between what you may define
22 as periodic health check-ups and what I might define it as.

23 DR. WALMSLEY: That may be. We are going to have
24 to see them before they have definite symptoms because still
25 too many come in with well defined syndromes and certainly



DR. WAINSLAY: That is right.

THE CHAIRMAN: Do you wish to carry on, Mr.

Major?

MR. MAJOR: I could carry on with this subject

for some time, Mr. Chairman. What I was trying to get here

was whether or not there was a cloudy interpretation by either

you or us. In my view any citizen who has a symptom, there is

no reason why they should not go to the doctor. With the

motivation of the periodic health examination, when there is

an individual of 50 years of age who is absolutely healthy

then we don't feel we should give him well adult care. If

anybody has any symptom, regardless of how slight it is, then

he has got a periodic health examination -- he is going to the

doctor and the health services usually pay for it on first

dollar coverage. There is a tremendous argument in principle

between people who have no symptoms and allowing people being

motivated with symptoms on the first dollar basis because they

can walk in and the coverage gives them the privilege of having

a check-up, but they have to have a symptom for their motivation

It is a matter of distinction between what you may define

as periodic health check-ups and what I might define it as.

DR. WAINSLAY: That may be. We are going to have

to see them before they have definite symptoms because still



1 don't require an extensive examination. We feel by putting
2 this in it is a step in the right direction. We are seeking
3 something better than that, surely.

4 MR. MAJOR: Paragraph 14 on page 4 referring to
5 Article 6 of the exemptions which excludes payment to the
6 General Practitioner for newborn infant care be deleted. Here
7 again I am wondering if we interpret this right. Do you say
8 during the first crucial week after birth the doctor's care is
9 important for the well-being of the newborn child. That is
10 why it is in here. The physician that has delivered the baby,
11 it is his duty to look after that child. He is being paid for
12 it in his confinement fee. If it is necessary because of some
13 peculiarity to transfer this child to a pediatrician then we
14 want to make a special issue of it and pay that pediatrician.
15 In other words we have the normal set up. We are trying to
16 take care of the abnormal here.

17 DR. WALMSLEY: We are quite aware of this. This
18 came up in discussions and this was raised mostly by physicians
19 in outlying areas. They are concerned there are not pediatri-
20 cians in those areas and maybe there is a child who needs
21 consultation with other doctors and other things. He may
22 communicate with somebody in Toronto about problems up in
23 Cochrane and cannot move the child. He is two days old.

24 THE CHAIRMAN: Pardon me. When Mr. Major
25 expresses himself as "we", he is not speaking for the Committee.



1 don't require an extensive examination. We feel by putting
2 this in it is a step in the right direction. We are seeking
3 something better than that, surely.

4 MR. MAJOR: Paragraph 14 on page 4 referring to
5 Article 6 of the exemptions which excludes payment to the
6 General Practitioner for newborn infant care be deleted. Here
7 again I am wondering if we interpret this right. Do you say
8 during the first crucial week after birth the doctor's care is
9 important for the well-being of the newborn child. That is
10 why it is in care. The physician that has delivered the baby.
11 It is his duty to look after that child. He is being paid for
12 it in his confinement fee. If it is necessary because of some
13 peculiarity to transfer this child to a paediatrician then we
14 want to make a special issue of it and pay that paediatrician.
15 In other words we have the normal set up. We are trying to
16 take care of the abnormal here.

17 DR. WALMSLEY: We are quite aware of this. This
18 came up in discussions and this was raised mostly by physicians
19 in outlying areas. They are concerned there are not paediatrici-
20 cians in those areas and maybe there is a child who needs
21 consultation with other doctors and other things. He may
22 communicate with somebody in Toronto about problems up in
23 Cochrane and cannot move the child. He is two days old.

24 THE CHAIRMAN: Pardon me. When Mr. Major
25 expresses himself as "we", he is not speaking for the Committee.



1 MR. MAJOR: Dr. Walmsley, on page 5, talking
2 about home care again and in your study of The Needs and
3 Resources at page 258, homemaker and nursing services. This
4 is carried on in certain municipalities. The homemaker service
5 has a yes by the City of Toronto, East York, Etobicoke, North
6 York and Scarborough. We have talked about costs. Are there
7 any costs available for these services from these organizations?
8 I wonder if these costs could be included?

9 DR. WALMSLEY: The cost of the home care?

10 MR. MAJOR: The homemaker service.

11 DR. WALMSLEY: I haven't got this Act available
12 with me.

13 MR. MAJOR: Again while we are on this subject
14 you mentioned page 122 and you read down to article 62 on that
15 page and then you continued to read but you may have been
16 reading some other page. Could you please tell me where you
17 continued to.

18 DR. WALMSLEY: Yes, I can give you those: Page
19 170, 171 and page 183.

20 MR. MAJOR: I think the question was asked as
21 to the number of people involved, the factor per thousand
22 population might need home care. What does the homemaker
23 service include? Does it include dusting and washing or
24 bathing the patient and feeding him his meals?

25 DR. WALMSLEY: This generally involves -- it



MR. MAJOR: Dr. Waimanley, on page 5, talking

about home care again and in your study of The Needs and

Resources at page 258, homemaker and nursing services. This

is carried on in certain municipalities. The homemaker service

has a year by the City of Toronto, East York, Etobicoke, North

York and Scarborough. We have talked about costs. Are there

I wonder if these costs could be included?

DR. WAIMANLEY: The cost of the home care?

MR. MAJOR: The homemaker service.

DR. WAIMANLEY: I haven't got that. Not available

MR. MAJOR: Again while we are on this subject

you mentioned page 128 and you read down to article 64 on that

page and then you continued to read but you may have been

reading some other page. Could you please tell me where you

DR. WAIMANLEY: Yes, I can give you those: Page

170, 171 and page 163.

MR. MAJOR: I think the question was asked as

to the number of people involved, the factor per thousand

population might need home care. What does the homemaker

service include? Does it include dressing and washing or

bathing the patient and feeding him his meals?



1 depends on the situation, as you can well imagine. Most of
2 these people are going into a home and it does require some
3 skilled nursing and ancillary skills as well. They may involve
4 some homemaker services in certain cases but wouldn't in all
5 of them.

6 MR. MAJOR: Let us take a 55 year old employee.
7 He is not very well employed. He has to work and his wife
8 had a cerebral and two or three months after there is evidence
9 rehabilitation is going to be very slow if there is going to
10 be any. This woman can't look after herself, she can't clean
11 the house, get the meals. Would the person that went in in
12 that case do the homemaker service and look after that house
13 for eight hours of the day while the husband was away?

14 DR. WALMSLEY: He is going to have a dusty house
15 whether his wife is there or not. I think it is another
16 problem. I think in home care we are concerned with the best
17 follow-up treatment and reducing the hospital stay.

18 MR. MAJOR: Home care service is primarily looking
19 after that individual, not the rest of the house.

20 DR. WALMSLEY: Not necessarily. Those are other
21 items.

22 MR. MAJOR: On page 6, paragraph 20: "Government
23 participation should not interfere with the autonomy, the
24 objects of the agency, or its freedom to do research or
25 experiment and enter into new fields of activity." The carrier



these people are going into a home, and it does require some skilled nursing and ancillary skills as well. They may involve some homemaker services in certain cases but wouldn't in all of them.

MR. MAJOR: Let us take a 55 year-old employee.

He is not very well employed. He has to work and his wife had a cerebral and two or three months after there is evidence rehabilitation is going to be very slow if there is going to be any. This woman can't look after herself, she can't clean the house, get the meals. Would the person that went in to that case do the homemaker service and look after that house for eight hours of the day while the husband was away?

MR. WAINWRIGHT: He is going to have a dusty house

whether his wife is there or not. I think it is another problem. I think in home care we are concerned with the best follow-up treatment and reducing the hospital stay.

after that individual, not the rest of the house.

DR. WAINWRIGHT: Not necessarily. There are other

ideas.

MR. MAJOR: On page 6, paragraph 20: "Government

participation should not interfere with the autonomy, the

object of the agency, or the freedom to do research or

experiment and enter into new fields of activity." The carrier



1 costs of the services provided would be paid by Government.
2 We are talking here of a sort of insurance in its broad sense.
3 Are you intimating that this insurance premium should include
4 various types of research of the organization on a cost basis
5 entering another field of activity. Supposing it decided it was
6 going to build swimming pools? Wouldn't we be only interested
7 in the actual cost of the services that the Government was
8 buying rather than any ancillary items of research or new
9 activity.

10 DR. WALMSLEY: This is what is implied here, Mr.
11 Major. These are actually specific organizations such as
12 V.O.N., voluntary organizations which are carrying out specific
13 health needs. Certainly we have said that it will only be the
14 actual cost of the service so that the difference is not made
15 necessary, going to United Appeal etcetera, but also that if
16 the Government guarantee that it would pay costs or the
17 Municipality paid all the costs of the services got and paid
18 for in the past then they wouldn't be afraid you are going too
19 far with the program.

20 MR. MAJOR: Thank you. I have a facetious
21 remark: On page 7, Dental Services, maybe we could legislate
22 against soft drinks.

23 MR. DUNN: Might I be permitted to supplement
24 the answer given to Mr. Major's last question in the Needs and
25 Resources Study there are recommendations which specifically



costs of the services provided would be paid by Government.
We are talking here of a sort of insurance in its broad sense.
Are you intimating that this insurance premium should include
various types of research of the organization on a cost basis
entering another field of activity. Supposing it decided it was
going to build swimming pools? Wouldn't we be only interested
in the actual cost of the services that the Government was
buying rather than any ancillary items of research or new
services?

DR. WALMSLEY: That is what is implied here, Mr.
Major. These are actually specific organizations such as
V.O.N., voluntary organizations which are carrying out specific
health needs. Certainly we have said that it will only be the
actual cost of the service so that the difference is not made
necessary, going to United Appeal etcetera, but also that if
the Government guarantee that it would pay costs or the
Municipality paid all the costs of the services got and paid
for in the past then they wouldn't be afraid you are going too
far with the program.

MR. MAJOR: Thank you. I have a question
remark: On page 7, Dental Services, maybe we could legislate
against self drinks.

MR. DUNN: Might I be permitted to supplement



1 cover that point that Mr. Major was raising. If I might just
2 give him the reference. It is on pages 181 and 182. That is
3 in the Needs and Resources Study, recommendations 120 to 122
4 inclusive. I don't think I need to read them. They are just
5 exactly what Dr. Walmsley said.

6 MR. MAJOR: Thank you, very much Dr. Walmsley.
7 That is all, Mr. Chairman.

8 THE CHAIRMAN: Mrs. Aylen, did you want to ask
9 something?

10 MRS. AYLEN: No, I think everything is covered.

11 THE CHAIRMAN: Do any other members of the
12 Committee have any questions?

13 MR. GALLOWAY: I have one question, I am very
14 interested in the powers of the members of the Committees that
15 you have. They are tremendous. I was interested first of all
16 how your Social Planning Committee was formed, what are its
17 responsibilities and who decides its powers, the Board of
18 Directors. How frequently do you meet and what action do you
19 take?

20 DR. WALMSLEY: I could refer this to Mr. Dunn.
21 We have it in our briefs. Mr. Lawson is also here. We have
22 it in our brief at the beginning in which we talk about our
23 program and the objectives of the Social Planning Council are
24 attached as appendix at the back of the brief. The objectives
25 and the work of the Council is outlined.



1 cover that point that Mr. Major was raising. If I might just
2 give him the reference. It is on pages 181 and 182. That is
3
4 inclusive. I don't think I need to read them. They are just
5 exactly what Mr. Wainwright said.

6 That is all, Mr. Chairman.
7
8 THE CHAIRMAN: Mrs. Aylen, did you want to ask
9 something?

10 THE CHAIRMAN: Do any other members of the
11 Committee have any questions?

12 MR. GALLAGHER: I have one question. I am very
13 interested in the powers of the members of the Committee that
14 you have. They are tremendous. I was interested first of all
15 how your Social Planning Committee was formed, what are its
16 responsibilities and who decides its powers, the Board of
17 Directors. How frequently do you meet and what action do you

18
19 MR. WATSON: I could refer this to Mr. Dunn.
20 We have it in our brief. Mr. Lawson is also here. We have
21 it in our brief at the beginning in which we talk about our
22 program and the objectives of the Social Planning Council are
23 attached as appendix at the back of the brief. The objectives
24 and the work of the Council is outlined.



1 MR. DUNN: Mr. Chairman, if I might be permitted
2 to supplement an answer that has been given: The Social
3 Planning Council of Metropolitan Toronto is a Corporation.
4 It has made use of the Welfare Council and the members of the
5 Council are twofold, first Welfare, Health Welfare and
6 Recreation Agencies in Metropolitan Toronto Government
7 departments and individuals.

8 The Board of Directors are elected annually
9 by vote of the members which could be organizations or individ-
10 uals and its role is as indicated to be a coordinating body,
11 completely voluntary, a coordinating body, a planning body
12 for all the various health, welfare and recreational agencies
13 and organizations in Metropolitan Toronto.

14 MR. GALLOWAY: You do make recommendations to
15 these individual members in the Associations that belong to the
16 Social Planning Council. Who do you make your recommendations
17 to?

18 MR. DUNN: I think it depends on what particularly
19 is being considered. For example, we are making recommendations
20 to this Commission today. There may be another group meeting
21 at this particular moment of two or three agencies who have
22 been brought together to try to settle the same common problem.

23 MR. GALLOWAY: The only other question I had
24 is that in the event that the Government did pay the total
25 cost of the social service, which you are recommending, do you



MR. DUNN: Mr. Graham, if I might be permitted

to supplement an answer that has been given: The Social Planning Council of Metropolitan Toronto is a Corporation. It has made use of the Welfare Council and the members of the Council are twofold, first Welfare, Health Welfare and Recreation Agencies in Metropolitan Toronto Government departments and individuals.

The Board of Directors are elected annually by vote of the members which could be organizations or individuals and its role is as indicated to be a coordinating body, completely voluntary, a coordinating body, a planning body for all the various health, welfare and recreational agencies and organizations in Metropolitan Toronto.

MR. GALLAGHER: You do make recommendations to these individual members in the Association that belong to the Social Planning Council. Who do you make your recommendations to?

MR. DUNN: I think it depends on what particular is being considered. For example, we are making recommendations to this Commission today. There may be another group meeting at this particular moment of two or three agencies who have been brought together to try to settle the same common problem.

MR. GALLAGHER: The only other question I had



1 see some great change in voluntary organizations; in their
2 activities?

3 DR. WALMSLEY: I would think that perhaps they
4 have been changing a bit in the last 20 years and as they
5 have grown, I presume they would change. I would presume there
6 would be other areas -- there has been a feeling in the past
7 where the voluntary agency led the Government would follow and
8 it took over, it expanded or went into other areas and provided
9 other services and this has happened in many instances and
10 undoubtedly they would change. They certainly could not be
11 static or they would not survive.

12 MR. GALLOWAY: Thank you sir.

13 THE CHAIRMAN: Dr. Walmsley most of the names
14 that are listed in your appendix here as members are those of
15 individuals, although the firm or institution with which they
16 are associated is listed along with their names. Do you have
17 associations as members or is it the individual in an associa-
18 tion that is a member?

19 MR. DUNN: The Association could be a member.
20 Now I just want to make one thing clear and that is Corporations
21 are not members nominating their President as their representa-
22 tive. We are speaking, of course, of voluntary community
23 supported agencies. There are two kinds of memberships, as I
24 mentioned. An agency can have a member, and then they can
25 nominate either one or two people as their representative or

MR. WAINWRIGHT: I would think that perhaps they

have been changing a bit in the last 20 years and as they have grown, I presume they would change. I would presume there would be other areas -- there has been a feeling in the past where the voluntary agency led the Government would follow and if took over, it expanded or went into other areas and provided other services and this has happened in many instances and undoubtedly they would change. They certainly could not be static or they would not survive.

MR. WAINWRIGHT: Thank you sir.

THE CHAIRMAN: Dr. Wainwright most of the names

that are listed in your appendix here as members are those of individuals, although the firm or institution with which they are associated is listed along with their names. Do you have associations as members or is it the individual in an association that is a member?

MR. WAINWRIGHT: The Association could be a member.

Now I just want to make one thing clear and that is Corporations are not members nominating their President as their representative. We are speaking, of course, of voluntary community supported agencies. There are two kinds of memberships, as I mentioned. An agency can have a member, and then they can nominate either one or two people as their representative or



1 an individual can be a member himself or herself and when I
2 am speaking of members, I am using "members" in a very technical
3 legal sense, similar to a shareholder in a Corporation.

4 Now the Social Planning Council, because of its
5 position in the community, is fortunately able to draw on the
6 best talents in the community and, therefore, people will
7 serve on committees for the Council who may not in themselves
8 be members in the sense of having paid an annual fee.

9 THE CHAIRMAN: Maybe I can state my question
10 better. Are you speaking for any other group of Associations,
11 other than the individual members of your Council?

12 MR. DUNN: Well we are speaking for the Council
13 itself. This could be different to the sum total of its
14 members, just the same as -- you will pardon me, being a
15 lawyer, a Corporation is different to its shareholders. I
16 just wanted to get straight that the Corporation, the Social
17 Planning Council speaks as such, and again, if I might Mr.
18 Chairman, this study was originally made by a Committee
19 appointed by the Board of Directors of the Council. The
20 Committee then prepared their brief. It was considered by the
21 Directors of the Council. It was approved by the Directors
22 of the Council and then it became a brief and the recommenda-
23 tions of the Council as such so what we are presenting to this
24 Committee or Commission this morning is the brief of the Social
25 Planning Council.



an individual can be a member himself or herself and when I am speaking of members, I am using "members" in a very technical legal sense, similar to a shareholder in a corporation.

Now the Social Planning Council, because of its

position in the community, is for the time being able to draw on the

best talents in the community and, therefore, people will

serve on committees for the Council who may not in themselves

be members in the sense of having paid an annual fee.

THE CHAIRMAN: Maybe I can state my question

better. Are you speaking for any other group of associations,

other than the national members of your Council?

MR. WHITE: Well we are speaking for the Council

itself. This would be different to the sum total of its

members, that the sum as -- you will pardon me, being a

lawyer, a corporation is different to its shareholders. I

Planning Council speaks as such, and again, if I might Mr.

Chairman, this study was originally made by a Committee

appointed by the Board of Directors of the Council. The

Committee then prepared their brief. It was considered by the

Directors of the Council. It was approved by the Directors

of the Council and then it became a brief and the recommenda-

tions of the Council as such as that we are presenting to this

Committee or Commission this morning as the brief of the Social

Planning Council.



1 THE CHAIRMAN: Thank you.

2 DR. BUTT: The Medical Service Insurance Act
3 Committee, these are the members really that produced the
4 brief. Is that correct?

5 DR. WALMSLEY: It had to go to our Health Section
6 of the Social Planning Council and it was gone into and it
7 went back to Committee and back again and finally up to the
8 Executive Committee of the Board of Directors.

9 DR. BUTT: All this is typical. All these
10 people, Dr. Anderson, Dr. Allison, Dr. Hastings, and so on
11 Dr. Burns Ross, I notice there are quite a few from the School
12 of Hygiene and I am wondering why the difference in their
13 personally reported brief to us on this, again we will come
14 back to this one specific thing the annual health examination
15 and what apparently has come out of this report.

16 DR. WALMSLEY: Again this was a Committee which
17 was probably wider than the group that introduced their report
18 from the School of Hygiene.

19 DR. BUTT: Now these members are all part of
20 your Social Planning Council?

21 MR. DUNN: Yes. They are for our present purpose.

22 DR. BUTT: How many would you have at an annual
23 meeting? I am just trying to get a conception of what is
24 going on.

25 MR. DUNN: Four hundred perhaps.

MR. CHAIRMAN: Thank you.

DR. BURN: The Medical Service Insurance Act

Committee, these are the members really that produced the

brief. Is that correct?

DR. WAINWRIGHT: It had to do so our Health Section

went back to committee and back again and finally up to the

Executive Committee of the Board of Directors.

DR. BURN: All that is typical. All these

people, Dr. Anderson, Dr. Allison, Dr. Hastings, and so on

Dr. Burns says, I notice there are quite a few from the School

of Hygiene and I am wondering why the difference in their

personally reported brief to us on this, again we will come

back to this one specific thing the annual health examination

and what apparently has come out of this report.

DR. WAINWRIGHT: Again this was a Committee which

was possibly wider than the group that introduced their report

from the School of Hygiene.

DR. BURN: Now these members are all part of

DR. BURN: Yes. They are for our present purpose

DR. BURN: How many would you have as an annual

meeting? I am just trying to get a conception of what is

going on.

DR. BURN: Four hundred perhaps.



1 THE CHAIRMAN: Any further questions?

2 MR. DUNN: Excuse me, if I might just add:

3 With a Board of Directors of forty-five.

4 THE CHAIRMAN: Do you have any further statement
5 Dr. Walmsley?

6 DR. WALMSLEY: No sir.

7 THE CHAIRMAN: Thank you very much.

8 DR. WALMSLEY: Thank you for your kind considera-
9 tion Mr. Chairman.

10 THE CHAIRMAN: The next submission we have is
11 from the Ontario Association of Social Workers.

12

13 BRIEF FROM THE ONTARIO ASSOCIATION OF SOCIAL

14 WORKERS

15 Appearances: Dr. Elizabeth Govan,
16 Miss Violet Munns,
17 Mr. John Haddad,
18 Mr. Ian Bain.

18

19 THE CHAIRMAN: Have you had an opportunity of
20 reading the statement of instructions there?

21 MISS MUNNS: Yes.

22 THE CHAIRMAN: Would you care to identify your
23 spokesman for your delegation?

24 MISS MUNNS: Yes. Mr. Chairman and members of
25 the Ontario Medical Service Insurance Enquiry, Miss Florence



THE CHAIRMAN: Any further questions?

MR. HUNN: Excuse me, if I might just add:

THE CHAIRMAN: Do you have any further statement

Dr. Wainwright?

DR. WAINWRIGHT: No sir.

THE CHAIRMAN: Thank you very much.

DR. WAINWRIGHT: Thank you for your kind considera-

tion Mr. Chairman.

THE CHAIRMAN: The next submission we have is

from the Ontario Association of Social Workers.

COMMITTEE

MR. HUNN.

THE CHAIRMAN: Have you had an opportunity of

reading the statement of instructions there?

MISS MANN: Yes.

THE CHAIRMAN: Would you care to identify your

spokesman for your delegation?

MISS MANN: Yes, Mr. Chairman and members of

the Ontario Medical Service Insurance Agency Miss Florence



1 Philpott, President of the Ontario Association of Social
2 Workers is out of town and she has asked me, as Secretary, to
3 represent her and introduce the members here. Dr. Elizabeth
4 Govan will be presenting the brief. Other members of the
5 Association are Mr. John Haddad and Mr. Ian Bain.

6 Now I will ask Dr. Govan to present our brief.

7 THE CHAIRMAN: I do not believe that I received
8 your name.

9 MISS MUNNS: Miss Violet Munns.

10 THE CHAIRMAN: Thank you. Yes Dr. Govan?

11 DR. GOVAN: Mr. Chairman, following your
12 instructions we do not intend to read this brief. We made
13 it short so that we did not submit a summary of it to you.
14 We thought it was a summary. We are delighted to have this
15 opportunity to appear before you and as we say in our intro-
16 duction we consider it very commendable that the Committee
17 should be prepared to hear the opinion of people in the
18 community on this particular subject.

19 The National Association presented a brief to
20 the Royal Commission on Health Services and took a stand on
21 health care program on a much wider basis and it was on the
22 basis of that national policy that this brief has been presented
23 to this Committee. We tried to direct our thinking particularly
24 to Bill 163 and, therefore, have limited ourselves specifically
25 to this. I think the major point I would like to draw out of



Philpott, President of the Ontario Association of Social Workers is out of town and she has asked me, as Secretary, to represent her and to present the brief. Other members of the Association are Mr. John Haddad and Mr. Ian Bain.

Now I will ask Dr. Govan to present our brief.

THE CHAIRMAN: I do not believe that I received

Your name.

THE CHAIRMAN: Thank you. Yes Dr. Govan?

We made instructions we do not intend to read this brief. We made it short so that we did not submit a summary of it to you. We thought it was a summary. We are delighted to have this opportunity to appear before you and as we say in our introduction we consider it very commendable that the Committee should be prepared to hear the opinion of people in the community on this particular subject.

The National Association presented a brief to the Royal Commission on Health Services and took a stand on health care program on a much wider basis and it was on the basis of that national policy that this brief has been presented to this Committee. We tried to direct our thinking particularly to Bill 163 and, therefore, have limited ourselves specifically to that. I think the major point I would like to draw out of



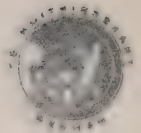
1 the brief is our recommendation for a much more comprehensive
2 health care plan. To the National Body we have emphasized that
3 a comprehensive plan is essential and I think we recognize
4 that a start should be made somewhere. We feel that the plan
5 should be drawn up as a whole, in the first place, to make
6 sure that the other parts are going to be fitted in or are
7 possible of being fitted in in the way in which the original
8 step has been taken. We question whether this applied in the
9 proposal under Bill 163. We find it very difficult to see
10 how the other services that we consider necessary for health
11 care could be worked in with this particular Bill.

12 We already have hospital insurance, of course,
13 and the combination of these two as completely separate
14 programs, as they are now suggested, suggest every aspect of
15 the further steps to medical care would also have to be taken
16 as discrete action. As I say, we would find it extremely
17 difficult to see the fitting into a comprehensive plan which
18 we consider extremely important.

19 I don't want to repeat what is in the brief,
20 Mr. Chairman. Shall I leave it at that and be waiting for
21 questions from the Committee?

22 THE CHAIRMAN: All right, thank you.

23 MISS CARPENTER: I think Dr. Govan we appreciate
24 the point of view that is expressed very clearly throughout
25 this brief, the question of comprehensive care and universal



the trial is our recommendation for a much more comprehensive
health care plan. To the National Body we have emphasized that
a comprehensive plan is essential and I think we recognize
that a shift needs to be made elsewhere. We feel that the plan
should be based on a shift in the first place, to make
sure that the other parts are going to be fitted in or are
possible of being fitted in in the way in which the original
step has been taken. We consider whether this applied in the
proposal under Bill 101. We find it very difficult to see
how the other matters that we consider necessary for health
care could be worked in with this particular Bill.

We already have hospital insurance, of course,
and the combination of those two is completely separate
programs, as they are now suggested, suggest every aspect of
the health care system would also have to be taken
as a discrete subject, as I say, we would find it extremely
difficult to see the fitting into a comprehensive plan which
we consider extremely important.

I don't want to repeat what is in the brief.

THE CHAIRMAN: Shall I leave it at that and be willing to
questions from the Committee?

THE CHAIRMAN: All right, thank you.

MISS GARRINER: I think Dr. Gowan we appreciate

the point of view that is extremely very clearly presented
that what, the question of comprehensive care and universal



1 coverage. Now one specific question that perhaps you would
2 be willing to clarify. On page 4 you raised the problem of
3 the medically indigent and go on to raise the question of how
4 a needy person will be defined and in the middle of that
5 paragraph you say it would not be possible to identify needy
6 persons on the basis of a means test, that a needs test would
7 have to be administered. Would you care to enlarge on the
8 thinking of this group?

9 DR. GOVAN: Yes. I think it is evident in our
10 brief we feel that the new Act would -- it is very doubtful
11 as to whether it would make any better provision than is
12 presently available in Ontario for the group that are now
13 receiving public assistance of various kinds and are included
14 under the Ontario Medical Care Plan and in the services given
15 by outpatient clinics in a hospital, and so on.

16 We are more concerned about the income level
17 just above that which can, with struggling, manage the ordinary
18 costs of everyday living but the minute they are faced with
19 some sort of emergency in the way of illness, their financial
20 situation is completely thrown. It is not necessary to tell
21 the Committee, of course, that the amount of illness will make
22 a tremendous difference in the way in which a family is thrown;
23 whether it involves one member of the family only or several
24 members are suffering from physical conditions that require
25 extra expenditures at the one time.

coverages. Now one specific question that perhaps you would
be willing to clarify. On page 4 you raised the problem of
the medically indigent and go on to raise the question of how
a needy person will be defined and in the middle of that
paragraph you say it would not be possible to identify needy
persons on the basis of a means test, that a needs test would
have to be administered. Would you care to enlarge on the
thinking of this group?

DR. GOVAN: Yes. I think it is evident in our

brief we feel that the new Act would -- it is very doubtful

as to whether it would make any better provision than it

receiving public assistance of various kinds and are included
under the Ontario Medical Care Plan and in the services given
by outpatient clinics in a hospital, and so on.

We are more concerned about the income level

just above that which can, with struggling, manage the ordinary
costs of everyday living but the minute they are faced with
some sort of emergency in the way of illness, their financial
situation is completely thrown. It is not necessary to tell
the Committee, of course, that the amount of illness will make
a tremendous difference in the way in which a family is thrown
whether it involves one member of the family only or several

extra expenditures at the one time.



1 It also depends very much, of course, on the
2 drugs and appliances, the sort of treatment that is necessary
3 for the kind of illness and that, therefore, the question of
4 taking a particular income level and saying that if you have
5 only this income you then could be considered needy does not
6 make sense because of the difference in expenses that the
7 medical care will mean for a particular family.

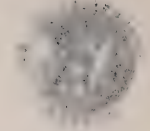
8 MISS CARPENTER: Are you saying in relation to
9 these extra expenses that are not covered by this Bill, and
10 you mentioned drugs, appliances, and so on in this paragraph,
11 that the present method by which these are paid for this low
12 income group is not satisfactory?

13 DR. GOVAN: To a large extent, these are not
14 paid for the income group above the public assistance level.

15 MISS CARPENTER: And voluntary agencies are not
16 able to handle this group in the grey area. Do you think they
17 go without necessary services that are part of their medical care.

18 DR. GOVAN: Very definitely. What is the use of
19 going to a doctor for a prescription if you have no money to
20 carry out the treatment that he has prescribed?

21 MISS CARPENTER: A suggestion has been made that
22 perhaps through the use of income tax returns one could assist
23 people of low income and raise the level on this medically
24 indigent group, so that there would be people getting assistance
25 who would have higher than the present income. Do you think



It also depends very much, of course, on the
for the kind of illness and that, therefore, the question of
taking a particular income level and saying that if you have
only this income you then could be considered needy does not
make sense because of the difference in expenses that the
medical care will mean for a particular family.

MISS CARPENTER: Are you saying in relation to
these extra expenses that are not covered by this Bill, and
you mentioned drugs, appliances, and so on in this paragraph,
that the present method by which these are paid for this low
income group is not satisfactory?

DR. GOVAN: To a large extent, these are not
paid for the income group above the public assistance level.

MISS CARPENTER: And voluntary agencies are not
able to handle this group in the grey area. Do you think they
go without necessary services that are part of their medical care?

DR. GOVAN: Very definitely. What is the use of
going to a doctor for a prescription if you have no money to

carry out the treatment that he has prescribed?

MISS CARPENTER: A suggestion has been made that

perhaps through the use of income tax return one could assist

people of low income and raise the level on this medically

indigent group, so that there would be people getting assistance

who would have higher than the present income. Do you think



1 this is a possibility?

2 DR. GOVAN: I would think, Mr. Chairman, that
3 the group that is probably most seriously affected by this is
4 the group that is not now paying income tax; with the
5 deductions, and so on, comes just under the income tax level.

6 MISS CARPENTER: They might be putting in returns
7 and be picked up this way.

8 DR. GOVAN: Yes. In some cases they would be
9 putting in returns but a large percentage of them are not.

10 MISS CARPENTER: I wonder if I am making my
11 question clear. If the Government were willing or through
12 this Bill were willing to accept the fact that people of higher
13 incomes than we now consider medically indigent were included
14 and given assistance in their premiums, would this not improve
15 the situation rather than, as you say, it would make the
16 situation worse or it would not help them?

17 DR. GOVAN: Yes. I think it would improve it
18 but I don't think it would solve it, Mr. Chairman. In
19 preparation of this meeting I became curious and made some
20 inquiries about the regulations of the Central Mortgage and
21 Housing about subsidizing rents on public housing programs and
22 I discovered that they take in their general regulations across
23 the whole of the country, and they say that public housing
24 should be available to people in the lower one-third of the in-
25 come group. This is below the income which the lower third of

1 This is a possibility?

2 DR. GOVAN: I would think, Mr. Chairman, that

3 the group that is probably most seriously affected by this is

4 the group that is not now paying income tax; with the

5 deduction, and so on, comes just under the income tax level.

6 MISS CARPENTER: They might be putting in returns

7 and be picked up this way.

8 DR. GOVAN: Yes. In some cases they would be

9 MISS CARPENTER: I wonder if I am making my

10 question clear. If the Government were willing or through

11 this Bill were willing to accept the fact that people of higher

12 incomes than we now consider medically indigent were included

13 and given assistance in their premiums, would this not improve

14 the situation rather than, as you say, it would make the

15 situation worse or it would not help them?

16 DR. GOVAN: Yes. I think it would improve it

17 but I don't think it would solve it, Mr. Chairman. In

18 preparation of this meeting I became curious and made some

19 inquiries about the regulations of the Central Mortgage and

20 Housing about subsidizing rents on public housing programs and

21 I discovered that they take in their general regulations across

22 the whole of the country, and they say that public housing

23 should be available to people in the lower one-third of the in-

24 come group. That is below the income which the lower third of



1 the population has. In other words, they are saying that for
2 housing we must subsidize housing up to one-third of our total
3 population.

4 Now if you are interested, Mr. Chairman, I have
5 some figures as to what this means in Toronto. This figure
6 means \$5,038.00 for a family requiring three bedrooms, which
7 means parents and three or four children. If this is taken
8 as any indication of the need of subsidization on housing,
9 and could be applied to medical care, this certainly talks
10 far above the income level we are talking about.

11 THE CHAIRMAN: Have talked about in the past you
12 mean?

13 DR. GOVAN: Yes.

14 THE CHAIRMAN: The other question was merely
15 one, more of a general one on page 6 of your brief where you
16 raised the question of citizens participation in the policy-
17 making body. If this group has specific recommendations to make
18 as to how this could be implemented, it might be of assistance
19 to the enquiry. This is a suggestion and there is no recomm-
20 endation as to how this might be accomplished.

21 DR. GOVAN: We left this open, Mr. Chairman,
22 because we are not sufficiently acquainted with the insurance
23 regulations to be sure. In the wording of the Act, as we see
24 it, in sections 8, 4 and 182 it looks to us as if the carriers
25 and the corporations include insurance representatives only



1 the population has. In other words, they are saying that for
2 housing we must subsidize housing up to one-third of our total
3 population.

4 Now if you are interested, Mr. Chairman, I have
5 some figures as to what this means in Toronto. This figure
6 means \$5,038.00 for a family requiring three bedrooms, which
7 means parents and three or four children. If this is taken
8 as any indication of the need of subsidization on housing,
9 and could be applied to medical care, this certainly talks
10 far above the income level we are talking about.

11 THE CHAIRMAN: Have talked about in the past you

12 meant?

13 DR. GOVAN: Yes.

14 THE CHAIRMAN: The other question was merely
15 one, more of a general one on page 6 of your brief where you
16 raised the question of citizens participation in the policy-
17 making body. If this group has specific recommendations to make
18 as to how this could be implemented, it might be of assistance
19 to the body. This is a suggestion and there is no recom-
20 endation as to how this might be accomplished.

21 DR. GOVAN: We left this open, Mr. Chairman,
22 because we are not sufficiently acquainted with the insurance
23 regulations to be sure. In the wording of the Act, as we see
24 it, in sections 8, 4 and 182 it looks to us as if the carriers
25 and the corporations include insurance representatives only



1 and no other people.

2 One possibility of getting consumer representa-
3 tion would be putting members on that body. As I listened to
4 part of the presentation of the previous brief on the question
5 of abuse, it seemed to me that the citizens participation in
6 the policy-making body was one way of controlling abuse.

7 MR. CASWELL: First of all, I, for one and I
8 am sure the Committee would like to congratulate you not just
9 for the brief but for the wonderful social effort that your
10 people are putting forth. I think it is most gratifying to
11 us to find the large number of people who are taking the
12 responsibility shall I say of being my brother's keeper and
13 certainly this is to be commended. Do you not find that there
14 is and always will be certain people who will not help them-
15 selves regardless of what is done for them? It just seems to
16 me in your brief you are suggesting that we must accept the
17 responsibility of all people regardless of whether they are
18 prepared to help themselves or not. Don't you think there is
19 a fair percentage of the population who just won't do anything
20 for themselves, even if they can?

21 DR. GOVAN: May I ask where you get the impression
22 that we think that we should help people whether they help
23 themselves or not?

24 MR. CASWELL: Your brief is going on to suggest
25 that not only should we give very comprehensive coverage, even

One possibility of getting consumer representa-
tion would be putting members on that body. As I listened to
of abuse, it seemed to me that the citizens participation in
one way of controlling abuse.
for the brief but for the wonderful social effort that your
people are putting forth. I think it is most gratifying to
us to find the large number of people who are taking the
responsibility shall I say of being my brother's keeper and
certainly this is to be commended. Do you not find that there
is and always will be certain people who will not help them-
selves regardless of what is done for them? It just seems to
me in your brief you are suggesting that we must accept the
responsibility of all people regardless of whether they are
prepared to help themselves or not. Don't you think there is
a fair percentage of the population who just won't do anything
for themselves, even if they can?

DR. GOVANI: May I ask where you get the impression
that we think that we should help people whether they help
themselves or not?

MR. CASWELL: Your brief is going on to suggest



1 to the extent of, shall we say, supplementing their living
2 expenses, and so on during periods of illness and I appreciate
3 that this has been done by comprehensive coverages by
4 insurance companies today but it is being done by people who
5 have provided for themselves and helped themselves accordingly.

6 We are always going to have a percentage of the
7 population who even in today's high standard of living and
8 excellent opportunity of employment will not help themselves.
9 They just won't. That is why we have a fair number of
10 unemployed. Not because of not always having jobs for them.
11 There will always be a percentage who won't work and help
12 themselves. I am just wondering if you have not found this
13 to be so and if you are prepared to recommend that these people
14 should be subsidized because the Government will keep them?

15 DR. GOVAN: May I make a personal comment?
16 This question has not come up in the discussion in the
17 Association. I don't know if I can speak for the Association
18 on it or not but I would feel that the question started on an
19 inaccurate premise in the first place because Government to
20 me is people helping themselves. That these people are part
21 of the citizens which Government represent and that, therefore,
22 through payment of taxes their subsidization is being paid by
23 the people who help themselves.

24 The other point: I think that any social worker
25 would agree that there are a number of people who do not want



to the extent of, shall we say, supplementing their living
that this has been done by comprehensive coverages by
insurance companies today but it is being done by people who
We are always going to have a percentage of the
population who even in today's high standard of living and
They just won't. That is why we have a fair number of
unemployed. Not because of not always having jobs for them.
There will always be a percentage who won't work and help
themselves. I am just wondering if you have not found this
to be so and if you are prepared to recommend that these people
should be subsidized because the government will keep them?
DR. GOVAN: May I make a personal comment?
This question has not come up in the discussion in the
Association. I don't know if I can speak for the Association
on it or not but I would feel that the question started on an
inaccurate premise in the first place because Government to
me is people helping themselves. That these people are part
of the citizens which Government represent and that, therefore,
through payment of taxes their subsidization is being paid by
the people who help themselves.

The other point: I think that any social worker



1 to work, who do not take employment, who are unwilling, if
2 you like, to help themselves in the way the rest of the
3 community does. I think this probably is very small. Without
4 getting into the question of unemployment, I would suggest it
5 is in the interests of the public that we should have as
6 healthy a population as possible and it is our objective to
7 try to make it easy for the people to receive the medical
8 attention they need, not only for their own development and
9 health, but for the welfare of the total community and that in
10 the question of health care our object is to promote health
11 and to find ways of encouraging people to use more medical
12 care.

13 When the question of abuse was discussed a few
14 minutes ago, I know of illustrations myself in which present
15 medical care plans are being abused by both patients and
16 doctors, because patients cannot abuse it without the doctors
17 going along with them in this particular instance, but the
18 people that we are concerned about in this medically indigent
19 group are the people who may or may not want medical care but
20 who are hesitant about obtaining medical care, in many
21 instances, because they cannot pay for it and that the cost
22 of the medical care is the thing which is preventing them from
23 getting medical care. I am not denying in that the suggestion
24 that there are some people who would prefer to be ill. I think
25 I might be free to give you an illustration that came to me



You like, to help themselves in the way the rest of the

getting into the question of unemployment, I would suggest it

is in the interests of the public that we should have as

healthy a population as possible and it is our objective to

try to make it easy for the people to receive the medical

attention they need, not only for their own development and

health, but for the welfare of the total community and that in

the question of health care our object is to promote health

and to find ways of encouraging people to use more medical

care.

When the question of abuse was discussed a few

minutes ago, I know of illustrations myself in which present

medical care plans are being abused by both patients and

doctors, because patients cannot abuse it without the doctors

going along with them in this particular instance, but the

people that we are concerned about in this medically indigent

group are the people who may or may not want medical care but

who are hesitant about obtaining medical care, in many

instances, because they cannot pay for it and that the cost

of the medical care is the thing which is preventing them from

getting medical care. I am not denying in that the suggestion

I might be free to give you an illustration that came to me



1 from another Province of a blind person who was recommended to
2 have surgical treatment with the hope that this would return
3 his sight and he refused to have it because if he did, he
4 would no longer get the blind allowance and this was the only
5 basis of security which he felt he could count on and in the
6 illustration I was given, at the age of 70, when the person
7 became eligible for old age security, he came and asked to
8 have the operation. Said now he did have some assistance,
9 some means of income on which he could live.

10 Now this is the relationship between financial
11 security and medical care. The fear of being dependant can
12 affect people both ways, that if, by being ill, you can get
13 more financial assistance, you may prefer to be ill. We don't
14 want that. We want people to be well and, therefore, we want
15 to encourage them to obtain the medical care that they need.

16 MR. CASWELL: Dr. Govan, I am very pleased that
17 I asked the question because I think the reason for the Bill,
18 and the reason we are here is because we feel just what you
19 have stated is correct. Medical care must be provided to
20 everyone. I wanted to see it in the record from someone such
21 as your organization.

22 There is one thing that is bothering a lot of
23 us, and that is perhaps how this is going to be paid for.
24 Under the Ontario Hospital Services Commission it's on a
25 contributory basis and I think that many of us, I am talking

have surgical treatment with the hope that this would return his sight and he refused to have it because if he did, he would no longer get the blind allowance and this was the only basis of security which he felt he could count on and in the illustration I was given, at the age of 70, when the person became eligible for old age security, he came and asked to have the operation. Said now he did have some assistance, some means of income on which he could live.

Now this is the relationship between financial security and medical care. The fear of being dependant can affect people both ways, that is, by being ill, you can get more financial assistance, you may prefer to be ill. We don't want that. We want people to be well and, therefore, we want to encourage them to obtain the medical care that they need.

MR. GOSWELL: Dr. Govan, I am very pleased that I asked the question because I think the reason for the Bill, and the reason we are here is because we feel that you have stated is correct. Medical care must be provided to everyone. I wanted to see it in the record from someone such

there is one thing that is bothering a lot of us, and that is perhaps how this is going to be paid for. Under the Ontario Hospital Services Commission it's on a contributory basis and I think that many of us, I am talking



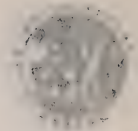
1 of individuals, have reason to believe that this has been
2 reasonably successful. Do you not feel this is a good way
3 to operate, as the Ontario Hospital Services Commission are
4 operating on a contributory basis?

5 DR. GOVAN: Are you referring to a recommendation
6 that this should be tax supported throughout?

7 MR. CASWELL: Yes.

8 DR. GOVAN: In making that recommendation to
9 the Royal Commission, we recognized that since the Hospital
10 Services has developed in different ways in different provinces,
11 that probably as medical care plans develop further they
12 would also follow different patterns from one Province to
13 another. We recommended the tax supported program as a
14 final goal, which I don't think realistically we could expect
15 to have right across the country, or in Ontario itself at
16 this stage, basically on the feeling that although income tax
17 is being subject to more and more criticism on it being a
18 method of taxation based on the ability to pay, it seems to
19 be the only way that you can most closely recognize the
20 ability of a person to pay and that, therefore, contributions
21 through tax can be adjusted through ability to pay more
22 adequately than the rate of contribution on an insurance basis
23 can.

24 MR. CASWELL: Have you some suggestion that
25 something like a sales tax perhaps called medical health tax



of individuals, have reason to believe that this has been reasonably successful. Do you not feel this is a good way to operate, as the Ontario Hospital Services Commission are operating on a contributory basis?

DR. GOVAN: Are you referring to a recommendation

that this should be tax supported throughout?

MR. CARSWELL: Yes.

DR. GOVAN: In making that recommendation to

Services has developed in different ways in different provinces that probably as medical care plans develop further they would also follow different patterns from one Province to another. We recommended the tax supported program as a final goal, which I don't think realistically we could expect to have right across the country, or in Ontario itself at this stage, basically on the feeling that although income tax is being subject to more and more criticism on its being a method of taxation based on the ability to pay, it seems to be the only way that you can most closely recognize the ability of a person to pay and that, therefore, contributions through tax can be adjusted through ability to pay more adequately than the rate of contribution on an insurance basis

MR. CARSWELL: Have you some suggestion that

something like a sales tax perhaps called medical health tax



1 might be a way of handling this rather than trying to do it
2 on an income tax basis? Has your Association given any thought
3 to this, that this tax then is paid by everybody and not by
4 a few?

5 DR. GOVAN: Yes.

6 MR. CASWELL: You haven't considered what type
7 of tax, simply a Government tax?

8 DR. GOVAN: We didn't go into this, Mr.
9 Chairman. I think the income tax is more possible, at least
10 being related to ability to pay would be an item in favour of
11 that rather than sales tax. It would depend a bit on what the
12 sales tax was on.

13 MR. CASWELL: On page 3, Dr. Govan, you comment
14 on universal coverage.

15 THE CHAIRMAN: A big tax on cadillacs, you
16 wouldn't mind.

17 MR. CASWELL: Page 3, in talking of universal
18 coverage the Bill provides as you suggest it is permissive both
19 with respect to those who elect to purchase medical insurance
20 and those for whom the Provincial or Municipal Governments pay
21 for. This is a democratic way of doing it, that people can
22 decide if they want to buy this coverage or they don't. I take
23 it from your brief you are suggesting that it should not be
24 on a permissive basis, it should be on a compulsory basis, that
25 persons in the Province should be covered regardless of whether



might be a way of handling this rather than trying to do it
on an income tax basis? Has your Association given any thought
to this, that this tax then is paid by everybody and not by
a few?

MR. CASWELL:

MR. CASWELL: You haven't considered what type

of tax, simply a Government tax?

DR. GOVAN: We didn't go into this, Mr.

Chairman. I think the income tax is more possible, at least
being related to ability to pay would be an item in favour of
that rather than sales tax. It would depend a bit on what the
sales tax was on.

MR. CASWELL: - On page 3, Dr. Govan, you comment

on universal coverage.

THE CHAIRMAN: A big tax on cadillacs, you

wouldn't mind.

MR. CASWELL: Page 3, in talking of universal

coverage the Bill provides as you suggest it is permissive both
with respect to those who elect to purchase medical insurance
and those for whom the Provincial or Municipal Governments pay
for. This is a democratic way of doing it, that people can
decide if they want to pay this coverage or they don't. I take
it from your brief you are suggesting that it should not be
on a permissive basis, it should be on a compulsory basis, that
persons in the Province should be covered regardless of whether



1 they wish to be covered or not.

2 DR. GOVAN: Yes, this is our feeling.

3 MR. CASWELL: Further on you are suggesting on
4 page 5 that the cost of medical insurance will take a gradual
5 increase, and I think we are inclined to agree that this is
6 very possible. "Further premiums will be weighted by medical
7 fee schedules and the Ontario Medical Association has been
8 given monopolistic control in setting these, that with the
9 introduction of medical insurance that the medical profession
10 will gradually keep increasing their fees and this is going to
11 increase their costs; is that the thinking?

12 DR. GOVAN: No, Mr. Chairman, this wording gives
13 that impression. We read from the Bill that the medical
14 Association would set their fees and the premium would be
15 established on the basis giving the Medical Association the
16 power to forever set fees. We wondered whether that was so.

17 MR. CASWELL: Good or bad.

18 DR. GOVAN: Good or bad.

19 MR. CASWELL: Thank you very much. Thank you,
20 Mr. Chairman.

21 THE CHAIRMAN: Dr. Hamilton.

22 DR. HAMILTON: I would like to ask about the
23 membership of the Association of Social Workers. Can you tell
24 me how many there are in the membership.

25 DR. GOVAN: The figures are on the first page

DR. GOVAN: The figures are on the first page

we how many there are in the membership.

membership of the Association of Social Workers. Can you tell
DR. HAMILTON: I would like to ask about the

THE CHAIRMAN: Dr. Hamilton.

MR. CASWELL: Thank you very much. Thank you.

DR. GOVAN: Good or bad.

MR. CASWELL: Good or bad.

power to forever set fees. We wondered whether that was so.
established on the basis giving the Medical Association the
Association would set their fees and the premium would be
that impression. We read from the Bill that the medical

DR. GOVAN: Mr. Mr. Chairman, this wording gives
themselves their coats; is that the thinking?

will gradually keep increasing their fees and this is going to
introduction of medical insurance that the medical profession
given monopolistic control in setting these, that with the
fee schedules and the Ontario Medical Association has been
very possible. "Further premiums will be weighted by medical
increase, and I think we are inclined to agree that this is
page 5 that the cost of medical insurance will take a gradual

MR. CASWELL: Further on you are suggesting on

DR. GOVAN: Yes, this is our feeling.

they wish to be covered or not.



1 of the brief. Ontario had one thousand and sixteen in the
2 beginning of this.

3 DR. HAMILTON: What is the distribution of
4 members.

5 DR. GOVAN: As you might expect a large
6 proportion are in Toronto. They are pretty heavy in the
7 larger centers rather than in the rural communities.

8 DR. HAMILTON: Are there any social workers
9 in towns of 25,000, say?

10 DR. GOVAN: Mr. Chairman, there would be some
11 in Childrens Aid Societies, for example, that would have their
12 headquarters in the County seat. They cover the whole of the
13 Counties.

14 DR. HAMILTON: But it is only the Childrens
15 Aid Society.

16 DR. GOVAN: In the smaller towns, probably.

17 DR. HAMILTON: That would have social workers.

18 DR. GOVAN: Professional social workers.

19 DR. HAMILTON: Can you tell me, I think for the
20 information of the Commission, the number of schools that have
21 social work in their program.

22 DR. GOVAN: At the moment two. At the moment
23 Waterloo is commencing. It is going to establish one. It
24 hasn't yet been done, but it is officially announced it is
25 going to be.

of the brief. Ontario had one thousand and sixteen in the beginning of this.

MR. HAMILTON: What is the distribution of

members.

MR. GOVAN: As you might expect a large

proportion are in Toronto. They are pretty heavy in the

large cities and in the large towns.

MR. HAMILTON: What about the rural areas?

in towns of 25,000, say?

MR. GOVAN: Mr. Chairman, there would be some

in Children's Aid Societies, for example, that would have their

headquarters in the County seat. They cover the whole of the

Councils.

MR. HAMILTON: But it is only the Children's

MR. GOVAN: In the smaller towns, probably.

MR. HAMILTON: That would have social workers.

MR. GOVAN: Professional social workers.

MR. HAMILTON: Can you tell me, I think for the

information of the Commission, the number of schools that have

social work in their program.

MR. GOVAN: At the moment two. At the moment

last year is commencing. It is going to establish one. It

hasn't yet been done, but it is officially announced it is

going to be.



1 DR. HAMILTON: There is one at the University
2 of Toronto.

3 DR. GOVAN: The other is St. Patrick's College,
4 University of Ottawa.

5 DR. HAMILTON: How many graduates per year are
6 there? I am asking this because in your brief to the Royal
7 Commission on Health Services there is quite a point about
8 shortage of personnel.

9 DR. GOVAN: I could get you the exact figures
10 on that, Mr. Chairman. Both the existing schools of Toronto
11 and Ottawa, and I would say the whole practice in North
12 America, the professional training is two years to Masters
13 Degree following a Bachelor of Arts. The school in Ottawa
14 would have in its two years about 65, I think something of that
15 sort. The school in Toronto at the moment has 165 and the
16 University has had to set restricted admission on this
17 because it is the only way it can be handled.

18 DR. HAMILTON: Is there a measure of the
19 shortage? Have you any idea of the magnitude of the shortage
20 in the Province of Social Workers.

21 DR. GOVAN: The only survey that has been made
22 was about ten years ago and it is out of date at this stage.
23 Efforts have been made at the moment to get the National Health
24 and Welfare Department to undertake a new survey and bring
25 that one up to date.



DR. HAMILTON: There is one at the University of Toronto.
DR. GOVAN: The other is St. Patrick's College, University of Ottawa.
DR. HAMILTON: How many graduates per year are there? I am asking this because in your brief to the Royal Commission on Health Services there is quite a point about shortage of personnel.
DR. GOVAN: I could get you the exact figures on that, Mr. Chairman. Both the existing schools of Toronto and Ottawa, and I would say the whole practice in North America, the professional training is two years to Masters Degree following a Bachelor of Arts. The school in Ottawa would have in its two years about 65, I think something of that sort. The school in Toronto at the moment has 105 and the University has had to set restricted admission on this because it is the only way it can be handled.
DR. HAMILTON: Is there a measure of the shortage? Have you any idea of the magnitude of the shortage in the Province of Social Workers.
DR. GOVAN: The only survey that has been made was about ten years ago and it is out of date at this stage. Efforts have been made at the moment to get the National Health and Welfare Department to undertake a new survey and bring that one up to date.



1 DR. HAMILTON: I only have one last question:
2 You recommend on page 3, paragraph in brackets 6, subsection
3 6 that the plan should be administered in such a way as to
4 provide citizen participation in the policy-making body. You
5 mention that in the Act the only administrative body mentioned
6 was the medical carriers organization. Are you recommending
7 that there should be a Board or Organization responsible for
8 advising the Government on broad policies?

9 DR. GOVAN: Mr. Chairman that paragraph quoted
10 is one that comes out of our National brief which was provid-
11 ing for a much wider scope of health care and we were trying
12 to apply this to the recommendation in Bill 163. I haven't gone
13 into detail as to how it could all be done because we are in
14 favour of this other set up rather than the Bill.

15 DR. HAMILTON: Thank you very much.

16 THE CHAIRMAN: Mr. Major.

17 MR. MAJOR: Dr. Govan, you made a statement that
18 it was impossible, and I leave the word impossible hanging,
19 I am not too sure that is what you said, for a citizen to
20 abuse health services without collusion with the physician.

21 THE CHAIRMAN: I think she qualified her
22 statement following that.

23 DR. GOVAN: I qualified that somewhat, but
24 insofar as treatment recommended has to be recommended by
25 the doctor, admission into the hospital, their prescriptions



DR. HAMILTON: I only have one last question:

Your recommendation on page 3, paragraph in brackets C, subsection

6 that the plan should be administered in such a way as to

provide citizen participation in the policy-making body. You

mention that in the Act the only administrative body mentioned

was the medical carriers organization. Are you recommending

that there should be a Board or organization responsible for

advising the Government on broad policies?

MR. GOVAN: Mr. Chairman that paragraph quoted

is one that comes out of our National brief which was provid-

ing for a much wider scope of health care and we were trying

to apply that to the recommendation in Bill 163. I haven't gone

into detail as to how it could all be done because we are in

favour of this other set up rather than the Bill.

MR. HAMILTON: Thank you very much.

THE CHAIRMAN: Mr. Major.

MR. MAJOR: Dr. Govan, you made a statement that

it was impossible, and I leave the word impossible hanging.

I am not too sure that is what you said, for a citizen to

phase health services without collision with the physician.

THE CHAIRMAN: I think she qualified her

statement following that.

DR. GOVAN: I qualified that somewhat, but

insofar as treatment recommended has to be recommended by



1 and so on, the doctor would presumably enjoin in this.

2 DR. HAMILTON: Under free choice it is not
3 possible for a citizen to...

4 DR. GOVAN: To go to the physician for services,
5 that is right.

6 MR. MAJOR: You said in the question and answer
7 period that you recommended a more comprehensive health service
8 to the Royal Commission. On page 2, paragraph 5, subsection
9 2 you recommend that a plan to provide comprehensive health
10 service should be established. Subparagraph 4 that universal
11 coverage is essential. I gather that comprehensive health
12 service includes all types of health services.

13 DR. GOVAN: Yes, Mr. Chairman, Sections 1 to 5 are
14 recommendations that came out of our National brief and we
15 incorporated them in here as broad principles. This is what
16 we would see as our ultimate objective.

17 MR. MAJOR: Have you any idea, and I am not
18 asking in respect of hospital services because hospital
19 services is now established, we are talking about physician
20 care, dental care, nursing, drugs, physio therapy, appliances
21 etcetera, have you any idea what this would cost, particularly
22 on a universal coverage basis?

23 DR. GOVAN: I have some figures on this, Mr.
24 Chairman. The Association has no staff to work out figures
25 of this nature and has to rely on figures from other people.



and so on, the doctor would presumably enjoin in this.

DR. HAMILTON: Under free choice it is not

possible for a citizen to...

MR. GOVAN: To go to the physician for services,

that is right.

MR. MAJOR: You said in the question and answer

period that you recommended a more comprehensive health service

to the Royal Commission. On page 2, paragraph 2, subsection

2 you recommend that a plan to provide comprehensive health

service should be established. Subparagraph A that universal

coverage is essential. I gather that comprehensive health

service includes all types of health services.

DR. GOVAN: Yes, Mr. Chairman.

recommendations that are out of our National brief and we

incorporated them in here as broad principles. This is what

we would see as our ultimate objective.

MR. MAJOR: Have you any idea, and I am not

asking in respect of hospital services because hospital

services are now established, we are talking about physician

care, dental care, nursing, drugs, physio therapy, appliances

etcetera, have you any idea what this would cost, particularly

on a universal coverage basis?

DR. GOVAN: I have some figures on this, Mr.

Chairman. The Association has no staff to work out figures

of this nature and has to rely on figures from other people.



1 I think our point of view would be this is a question of
2 priorities. If we believe in medical care we have to pay
3 for it. If we have the manpower, the cost -- we are saying
4 we can't afford to let people get medical care. I don't think
5 the actual figure of cost matters. It is a question of how
6 convinced we are that medical care is a necessity of life in
7 present civilization and it should be available to all people
8 regardless of their individual ability to pay for it.

9 MR. MAJOR: These costs would be approximately
10 \$500,000,000. a year. You think that the Province could
11 afford it?

12 DR. GOVAN: The question is not whether we can
13 afford it but whether we can afford not to.

14 MR. MAJOR: You indicate that you want universal
15 coverage, everybody should be covered in this, it shouldn't
16 be voluntary, it should not be elective. I gather then you
17 are intimating that the present system whereby possibly some
18 60 to 70% of the population is now covered for a fair amount
19 of health services should be destroyed. You would eliminate
20 that and replace that with a new set up altogether.

21 DR. GOVAN: The last figure I have is 57% in
22 Ontario.

23 MR. MAJOR: Fine, it is more than 50%, let us
24 say 57%. You would replace all this.

25 DR. GOVAN: Yes.



I think our point of view would be that is a question of priorities. If we believe in medical care we have to pay for it. If we have the manpower, the cost -- we are saying we can't afford to let people get medical care. I don't think the actual figure of cost matters. It is a question of how convinced we are that medical care is a necessity of life in present civilization and it should be available to all people regardless of their individual ability to pay for it.

MR. MAJOR: These costs would be approximately

\$500,000,000 a year. You think that the Province could

afford it?

DR. GOVAN: The question is not whether we can

afford it but whether we can afford not to.

MR. MAJOR: You indicate that you want universal

coverage, everybody should be covered in this, it should be voluntary, it should not be selective. I gather then you are insisting that the present system whereby possibly some 60 to 70% of the population is now covered for a fair amount of health services should be destroyed. You would eliminate that and replace that with a new set up altogether.

DR. GOVAN: The last figure I have is 57% in

Ontario.

MR. MAJOR: Fine, it is more than 50%, let us

say 57%. You would replace all that.



1 MR. MAJOR: Do you think the means test should
2 be done away with?

3 DR. GOVAN: I think there is a place for a means
4 test, Mr. Chairman. I am speaking personally on this point.
5 I think the proportion of people to which one would have to
6 apply the means test in order to determine whether or not the
7 medical care should be subsidized or paid for completely would
8 make administration costs extremely high and would invalidate
9 the use of means test in this situation. I also, and I think
10 this is a matter of opinion and I don't know whether social
11 workers could prove it, if we say we want people to get medical
12 care and we expect the person with the relatively low income
13 to say that at the beginning of the year I am going to need
14 medical care I have to go and have a means test to get it, to
15 have my insurance premiums paid -- they just wouldn't go. I
16 am thinking of the medically indigent group, not the public
17 assistance group with whom people will be working and be in
18 a position to make this arrangement almost automatically because
19 a means test has already been given. If we are referring to
20 the upper income group, upper in comparison with the public
21 assistance group, I am thinking they are going to go in advance
22 to have a means test in order to have their insurance premium
23 paid, I don't believe it, partly because a large proportion
24 of these people are saying we will manage somehow. We don't
25 want a means test. We want to live on our income.

want a means test. We want to live on our income.

of these people are saying we will manage somehow. We don't

paid. I don't believe it, partly because a large proportion

to have a means test in order to have their insurance premium

assistance group. I am thinking they are going to go in advance

the upper income group, upper in comparison with the public

a means test has already been given. If we are referring to

a position to make this arrangement almost automatically because

am thinking of the medically indigent group, not the public

have my insurance premiums paid -- they just wouldn't go. I

medical care I have to go and have a means test to get it, to

to say that at the beginning of the year I am going to need

care and we expect the person with the relatively low income

workers could prove it, if we say we want people to get medical

this is a matter of opinion and I don't know whether social

the money is not a means test. I don't know.

make administration costs extremely high and would invalidate

medical care should be subsidized or paid for completely would

apply the means test in order to determine whether or not the

I think the proportion of people to which one would have to

test, Mr. Chairman. I am speaking personally on this point.

DR. GOVAN: I think there is a place for a means

be gone away with?

MR. MAJOR: Do you think the means test should



1 MR. MAJOR: They would give up medical care or
2 health services because of the means test but they wouldn't
3 give up their groceries because of their means test, they would
4 still go and have a means test to get food.

5 DR. GOVAN: I am talking about the group above
6 this level, Mr. Major, the people who are ordinarily independ-
7 ent but when it becomes a question of health and medical
8 expenses become dependent.

9 MR. MAJOR: I find it difficult to remove it
10 from the fellow with a dollar and the fellow with the dollar
11 and a quarter. If the means test is degrading for the proud
12 or hurts the individual -- it doesn't hurt the fellow who is
13 getting it for food or shelter.

14 DR. GOVAN: I quite agree. I take the point of
15 view it shouldn't be degrading, but the community makes it
16 degrading by their attitude today that places a stigma upon
17 those people.

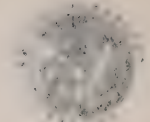
18 MR. MAJOR: It is a result of living together
19 of people and their discriminations and so on.

20 DR. GOVAN: And the value we place on material
21 independence.

22 MR. MAJOR: This has to be decided on a
23 reasonably discretionary basis, how you are going to apply it.

24 DR. GOVAN: Yes.

25 MR. MAJOR: Thank you.



MR. MAJOR: They would give up medical care or

health services because of the means test but they wouldn't

give up their groceries because of their means test, they would

still go and have a means test to get food.

MR. GOVAN: I am talking about the group above

this level, Mr. Major, the people who are ordinarily independ-

ent but when it becomes a question of health and medical

MR. MAJOR: I find it difficult to remove it

from the fellow with a dollar and the fellow with the dollar

and a quarter. If the means test is degrading for the poor

or makes an individual -- it doesn't hurt the fellow who is

getting it for food or shelter.

MR. GOVAN: I quite agree. I take the point of

view it shouldn't be degrading, but the community makes it

degrading by their attitude today that places a stigma upon

those people.

MR. MAJOR: It is a result of living together

of people and their discriminations and so on.

MR. GOVAN: And the value we place on material

MR. MAJOR: This has to be decided on a

reasonably discretionary basis how you are going to apply it.



1 I think that is all, Mr. Chairman.

2 THE CHAIRMAN: Miss McArthur?

3 MISS McARTHUR: I think that my question was
4 partly answered. I was interested in the citizen participation
5 in the policy-making body. I think you answered the question.
6 I was interested in the "how". You have indicated you haven't
7 given more consideration as to how.

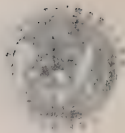
8 DR. GOVAN: Not within this organization suggested
9 by this Bill. It is in the other context.

10 MR. MAJOR: I have one further question. I
11 forgot the appendix to the brief. On page 3 of the brief to
12 the Royal Commission you speak of social assessment. Can you
13 give us a little outline of what social assessment means, if
14 you would, Dr. Govan, and included in your statement you refer
15 to in the next page "social components".

16 DR. GOVAN: Page 3 of the Royal Commission brief ?

17 MR. MAJOR: Under social worker's function, the
18 social worker's function in the middle of the page. In para-
19 graph one you speak of social assessment. On the next page
20 following, paragraph 8, you speak of social components. This
21 is purely for education because I don't understand it. I don't
22 know anything about it.

23 DR. GOVAN: Social assessment is basically the
24 way in which this person lives with his fellow beings and how
25 he adjusts to them. Taking it in a pretty narrow sense in the



I think that is all, Mr. Chairman.

THE CHAIRMAN: Miss McArthur?

MISS MCARTHUR: I think that my question was

partly answered. I was interested in the citizen participation in the policy-making body. I think you answered the question. I was interested in the "how". You have indicated you haven't given more consideration as to how.

DR. GOVAN: Not within this organization suggested

by this Bill. It is in the other context.

MR. MAJOR: I have one further question. I

forgot the appendix to the brief. On page 3 of the brief to the Royal Commission you speak of social assessment. Can you give us a little outline of what social assessment means, if you would, Dr. Govan, and included in your statement you refer to in the next page "social components".

DR. GOVAN: Page 3 of the Royal Commission brief

MR. MAJOR: Under social workers' function, the social worker's function in the middle of the page. In paragraph one you speak of social assessment. On the next page following, paragraph 8, you speak of social components. This is a very broad term, I think, and I don't know anything about it.

DR. GOVAN: Social assessment is basically the way in which this person lives with his fellow beings and how he adjusts to them. Taking it in a pretty narrow sense in the



1 application of disability allowance in a social assessment the
2 disability allowance is a heavy component of the degree of
3 self care the person is capable of. The study is made as to
4 what this person does on his own, can he walk upstairs, does
5 he need to have help, does he need to be fed and so on, what
6 are the possibilities of employment, not only on the basis of
7 his physical being but because of the way in which it limits
8 his activities and his attitude to his physical being and his
9 motivation to rehabilitation. Does that give it to you in
10 a specific instance?

11 MR. MAJOR: That gives it to me.

12 THE CHAIRMAN: Mrs. Aylen?

13 MRS. AYLEN: Do you believe that there are many
14 people who need artificial limbs and appliances of that kind
15 who don't get them under some system in our society?

16 DR. GOVAN: If I could defer that to Mr. Bain
17 who has a little experience in this area.

18 MR. BAIN: Personally, speaking personally I
19 would venture the opinion that this type of assistance with
20 appliances and the like is available through voluntary agencies
21 in many cases for physically handicapped adults. In other
22 instances it would be available through federally supported
23 services such as the Veterans Affairs and this type of thing.
24 I don't think we discussed this in regard to this type of
25 coverage. I think there is a fairly comprehensive availability



2 disability allowance is a heavy component of the degree of
3 self care the person is capable of. The study is made as to
4 what this person does on his own, can he walk upstairs, does
5 he need to have help, does he need to be fed and so on, what
6 are the possibilities of employment, not only on the basis of
7 his physical being but because of the way in which it limits
8 his activities and his attitude to his physical being and his
9 motivation to rehabilitation. Does that give it to you in
10 a specific instance?

MR. MAJOR: That gives it to me.

THE CHAIRMAN: Mrs. Aylen?

MRS. AYLEN: Do you believe that there are many

people who need artificial limbs and appliances of that kind
who don't get them under some system in our society?

DR. GOVAN: If I could defer that to Mr. Bain

who has a little experience in this area.

MR. BAIN: Personally, speaking personally I

would venture the opinion that this type of assistance with

in many cases for physically handicapped adults. In other

services such as the Veterans Affairs and this type of thing.

I don't think we discussed this in regard to this type of



1 of this type of thing, at least in Ontario. That is what we
2 are concerned about here and I would think that this is
3 available to most children and adults on a voluntary basis.

4 MRS. AYLEN: The second question, do you recommend
5 on the comprehensive plan, supposing you couldn't have that,
6 but considering denture, glasses and drugs, which would be
7 first in order, the greatest need?

8 DR. GOVAN: I don't know how one could answer
9 that. It depends so much on the individual. May I add here
10 I heard this from an older person who needed dentures. He
11 was a person on public assistance, not in Toronto, but in an
12 Ontario community. The Welfare Department wanted to know what
13 the prognosis of life was, what was the use of giving dentures
14 unless you had at least so many years to live. This is the
15 sort of thing that social workers get in communities.

16 MRS. AYLEN: You didn't put them in the order I
17 asked.

18 MR. BAIN: I would think some of these things
19 that are mentioned are available through voluntary agencies.
20 Again, perhaps, this is something that cannot be depended upon
21 in all situations. They may be available here and not else-
22 where from County to County. A lot are provided through the
23 service clubs which in some cases, children requiring glasses,
24 they will provide the glasses. There may be others. I don't
25 know of any that provide dentures, but glasses would be

25 know of any that provide dentures, but glasses would be

24 they will provide the glasses. There may be others. I don't

23 service clubs which in some cases, children requiring glasses,

22 where from County to County. A lot are provided through the

21 in all situations. They may be available here and not else-

20 Again, perhaps, this is something that cannot be depended upon

19 that are mentioned are available through voluntary agencies.

18 MR. BAIN: I would think some of these things

17 asked.

16 MRS. AYLMER: You didn't put them in the order I

15 sort of thing that social workers get in communities.

14 unless you had at least so many years to live. This is the

13 the prognosis of life was, what was the use of giving dentures

12 Ontario community. The Welfare Department wanted to know what

11 was a person on public assistance, not in Toronto, but in an

10 I heard this from an older person who needed dentures. He

9 that. It depends so much on the individual. May I add here

8 DR. GOVAN: I don't know how one could answer

7 first in order, the greatest need?

6 but considering denture, glasses and drugs, which would be

5 on the comprehensive plan, supposing you couldn't have that,

4 MRS. AYLMER: The second question, do you recommend

3 available to most children and adults on a voluntary basis.

2 are concerned about here and I would think that this is



1 available from place to place, service clubs and other
2 organizations that would give them.

3 DR. GOVAN: May I comment, Mr. Chairman, that
4 the demands for these things through voluntary agencies shows
5 how different people find ways to pay for them themselves,
6 and therefore raises the question as to whether these things
7 should be provided for voluntarily, on a voluntary basis.

8 MRS. AYLEN: Would you like to destroy all the
9 voluntary effort.

10 DR. GOVAN: No.

11 MRS. AYLEN: Thank you very much.

12
13 MISS MUNNS: Could I add to this? There are
14 people who frequently do without necessary food and
15 clothing and shelter they should have in order to meet the
16 cost of drugs, in particular and dental costs are pretty high
17 to meet too. I think we should not think just because there
18 are voluntary agencies prepared to do a little of this it by
19 any means means that the situation is all right. My
20 impression is there would be lots of things for them still to
21 do with the comprehensive health care plan.

22 THE CHAIRMAN: Dr. Galloway.

23 DR. GALLOWAY: I have just one question: I am
24 concerned about the lack of personnel. I wonder if this is
25 due to insufficient remuneration or insufficient people who



available from place to place, service clubs and other

DR. GOWAN: May I comment, Mr. Chairman, that

the demands for these things through voluntary agencies shows

how different people find ways to pay for their themselves,

and therefore raises the question as to whether these things

should be provided for voluntarily, on a voluntary basis.

MRS. AYLMER: Would you like to destroy all the

MR. GOWAN: No.

MRS. AYLMER: Thank you very much.

people who frequently do without necessary food and

clothing and shelter they should have in order to meet the

cost of drugs, in particular and dental costs are pretty high

to meet too. I think we should not think just because there

are voluntary agencies prepared to do a little of this it by

any means means that the situation is all right. My

impression is there would be lots of things for them still to

do with the comprehensive health care plan.

THE CHAIRMAN: Dr. Galloway.

DR. GALLOWAY: I have just one question: I am

concerned about the lack of personnel. I wonder if this is

due to insufficient remuneration or insufficient people who



1 have the high intelligence of those of you already in it.

2 DR. GOVAN: The salaries of social workers have
3 been going up. In the Toronto area they are now starting at
4 \$5400.00 and graduation, as of this year. This is higher than
5 in some other communities but in most of Ontario Toronto sets
6 the standard because they are competing with them for staff
7 and they have to reach the same standard. I think, Mr.
8 Chairman, a great deal of the shortage has the same cause as
9 the shortage in nursing, the shortage in teaching that had
10 to be dealt with under emergency conditions. There are not
11 enough people in this age group with University education in
12 the case of social workers, they have such a wide choice of
13 professions at that stage, all of which are demanding their
14 services and doing their best to induce them into their folds.
15 There is a highly competitive situation for young people at
16 this stage.

17 THE CHAIRMAN: Dr. Butt.

18 DR. BUTT: You spoke about social assessment and
19 social components and so on. In another brief, it actually
20 hasn't been given, talked about social justice payments. As
21 far as I can figure out what he was suggesting was everybody,
22 indigent or not, by virtue of being in this Province of Ontario
23 deserved to get money for his medical care. This should be
24 given to him as an individual and he can then purchase through
25 choice. What is your opinion on this? Do you think that this



have the high intelligence of those of you already in it.
DR. GOVAN: The salaries of social workers have
been going up. In the Toronto area they are now standing at
\$2400.00 and graduation, as of this year. This is higher than
in some other communities but in most of Ontario Toronto sets
the standard because they are competing with them for staff
and they have to reach the same standard. I think, Mr.
Chairman, a great deal of the shortage has the same cause as
the shortage in nursing, the shortage in teaching that had
to be dealt with under emergency conditions. There are not
enough people in this age group with University education in
the case of social workers, they have such a wide choice of
professions at that stage, all of which are demanding their
services and doing their best to induce them into their folds.
There is a highly competitive situation for young people at
this stage.

MR. BOWEN: You spoke about social assessment and
social components and so on. In another brief, it actually
hasn't been given, talked about social justice payments. As
far as I can figure out what he was suggesting was everybody,
indigent or not, by virtue of being in this Province of Ontario
deserved to get money for his medical care. This should be
given to him as an entitlement and he can then choose among
choices, what is your opinion on that, Mr. Chairman?



1 could work and how would one do it. You are a social worker.
2 You know all the problems.

3 DR. GOVAN: Sort of like an old Social Credit
4 idea.

5 DR. BUTT: I am not proposing it. I am asking
6 for education.

7 DR. GOVAN: I am interested that you relate this
8 to our comments of social assessment.

9 DR. BUTT: Now, I am just saying those are terms
10 and this is another term that was used and this particular
11 individual felt it was just for the sake of the individual
12 that he should not be told how to do everything but given his
13 amount of money because he is indigent or in a less fortunate
14 situation. He is then in the position of being capable of
15 looking after himself. Do you as a social worker go along with
16 this idea or not, if the money were provided in that way.

17 DR. GOVAN: I don't know if I can say I have
18 an opinion as a social worker.

19 DR. BUTT: Well, as an organization.

20 DR. GOVAN: The organization as far as I know
21 hasn't discussed this particular point, has it? If you accept
22 Lord Beveridge's view that there should be a blanket below
23 which nobody should fall, one way of providing the blanket is
24 to provide everybody with a certain income and whatever you get
25 above that is your own. I would certainly think social workers

could work and how would one do it. You are a social worker.

DR. GOVAN: Someone like an old Social Credit

DR. BUTT: I am not proposing it. I am asking

DR. GOVAN: I am interested that you relate this

to our concepts of social assessment.

DR. BUTT: Now, I am just saying those are terms

and this is another term that was used and this particular

individual felt it was just for the sake of the individual

attention. He is then in the position of being capable of

looking after himself. Do you as a social worker go along with

this idea or not, if the money were provided in that way.

MR. GOVAN: I don't know if I can say I have

an opinion as a social worker.

DR. BUTT: Well, as an organization.

MR. GOVAN: The organization as far as I know

hasn't discussed this particular point, has it? If you accept

Lord Beveridge's view that there should be a blanket below

which nobody should fall, one way of providing the blanket is



1 would support the idea that the person has the right to decide
2 how he is going to spend his money himself and that it is his
3 responsibility to do it. At the same time, again from the
4 social worker's point of view a great many people need help
5 in this, and I think medical care is one of the very definite
6 cases in point. A great many people don't seek care, partly
7 because they are scared of what the doctor will tell them when
8 they get there. They prefer to be sick than to go to a doctor
9 or they are frightened of the implications of what the doctor
10 will say, both financially and physically to them. You have,
11 and perhaps Miss Munns could give illustrations of this, you
12 get mothers for example who refuse surgery because their
13 families cannot do without them for this length of time and
14 they would rather be sick than go into a hospital and follow
15 the doctor's recommendation. There are large numbers of
16 reasons for which people don't seek medical care and it is
17 all related to the complexity of personality, not just ignorance
18 or unwillingness to help oneself and so on.

19 DR. BUTT: In this instance they are provided
20 with the financial means for obtaining it, they are given the
21 choice of obtaining it or not. Do you think this is the way
22 it should be done or not, this is the essence of the brief.

23 DR. GOVAN: Theoretically it is possible.

24 DR. BUTT: You would agree that this is a way
25 of doing it.



1 would support the idea that the person has the right to decide
2 how he is going to spend his money himself and that it is his
3 responsibility to do it. At the same time, again from the
4 social worker's point of view a great many people need help
5 in this, and I think medical care is one of the very definite
6 cases in point. A great many people don't seek care, partly
7 because they are afraid of the doctor, partly because
8 they get there. They prefer to be sick than to go to a doctor
9 or they are frightened of the implications of what the doctor
10 will say, both financially and physically to them. You have,
11 and perhaps Miss Hanna could give illustrations of this, you
12 have families cannot do without them for this length of time and
13 they would rather be sick than go into a hospital and follow
14 the doctor's recommendation. There are large numbers of
15 persons too which people don't seek medical care and it is
16 all related to the complexity of personality, not just ignorance
17 or unwillingness to help oneself and so on.
18 DR. BUTT: In this instance they are provided
19 with the financial means for obtaining it, they are given the
20 choice of obtaining it or not. Do you think this is the way
21 it should be done or not, this is the essence of the brief.
22 DR. GOWAN: Theoretically it is possible.
23 DR. BUTT: You would agree that this is a way



1 DR. GOVAN: I would say it is one possible way.
2 I wouldn't say I would support it.

3 DR. BUTT: I am trying to find out whether you
4 support it as an individual. I think you covered it, you
5 agree but you don't know whether you would support it.

6 MR. SIMON: I don't know if I understand it
7 properly. The question as I understand it is of a subsidy
8 to certain groups to a certain level. The question is whether
9 we recommend it, whether the Government covers them by insurance
10 or give them the money so they can buy their own insurance.

11 DR. BUTT: Yes. I wondered what the social
12 worker's reaction was.

13 DR. GOVAN: I would go one step further than
14 that. Talking about the shortage of social workers there are
15 also shortages of medical personnel and medical facilities and
16 so on. You still have to be able to get the service.

17 MR. CASWELL: Mr. Chairman, I think the brief
18 Dr. Govan has presented points out that she wouldn't be in
19 favour of giving persons money. Her Association is not in
20 favour of a permissive effect on this. It must be universal,
21 everyone must be covered.

22

23

24

25

DR. GOVAN: I would say it is one possible way.

I wouldn't say I would support it.

DR. BUTT: I am trying to find out whether you

support it or not. I think you would support it.

agrees but you don't know whether you would support it.

MR. SIMON: I don't know if I understand it

properly. The question as I understand it is of a subsidy

to certain groups to a certain level. The question is whether

we recommend it, whether the Government covers them by insurance

or give them the money so they can buy their own insurance.

DR. BUTT: Yes. I wondered what the social

worker's reaction was.

DR. GOVAN: I would go one step further than

that. Talking about the shortage of social workers there are

also shortages of medical personnel and medical facilities and

so on. You still have to be able to get the service.

MR. GARDNER: Mr. Chairman, I think the brief

Dr. Govan has presented points out that she wouldn't be in

favour of giving persons money. Her Association is not in

favour of a permissive effect on this. It must be universal.

everyone must be covered.



1 This is what the brief here says. If you are
2 going to give the money, then it is still permissive and the
3 individual may go and buy medical insurance or may not. If
4 your brief is to stand up--the brief says don't start that. It
5 must be universal coverage. Everyone must have medical cover-
6 age whether they desire it or don't desire it. That is what I
7 read on page 3, number 8 under universal coverage.

8 DR. GOVAN: We say it should be compulsory. I
9 don't think that was certainly not taken in with the possible
10 alternative of giving everybody money to cover everything.

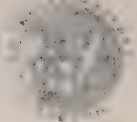
11 MR. CASWELL: Dr. Govan giving them the money
12 it is not compulsory. It is permissive. They have the money
13 and they can spend it on candy or medical insurance.

14 DR. GOVAN: That is true.

15 THE CHAIRMAN: Does this clear up your question?

16 MR. CASWELL: I think I have a fair idea of
17 what this particular group are saying. Thank you very much.

18 THE CHAIRMAN: Dr. Govan I realize that the
19 attitude or the desire of your Council is that there should
20 be comprehensive coverage for everyone but then you have also
21 recognized that at the present time that may not be a possibility.
22 You have stated that you are not in favour of the means test.
23 You say that there needs to be a needs test. I can fully
24 appreciate your thinking along that line that where, for
25 instance, a \$500.00 medical bill may not be too burdensome for



This is what the brief here says. If you are
going to give the money, then it is still permissive and the
individual may go and buy medical insurance or may not. If
age whether they desire it or don't desire it. What is what I
need on page 3, number 8 under universal coverage.
DR. GOVAN: We say it should be compulsory. I
don't think that was certainly not taken in with the possible
alternative of giving everybody money to cover everything.
MR. GOSWAMI: Dr. Govan giving them the money
it is not compulsory. It is permissive. They have the money
and they can spend it on candy or medical insurance.
DR. GOVAN: That is true.
THE CHAIRMAN: Does this clear up your question?
MR. GOSWAMI: I think I have a fair idea of
what this particular group are saying. Thank you very much.
THE CHAIRMAN: Dr. Govan I realize that the
attitude on the desire of your Council is that there should
be comprehensive coverage for everyone but then you have also
recognized that at the present time that may not be a possibility.
You have stated that you are not in favour of the means test.
You say that there needs to be a needs test. I can fully
appreciate your thinking along that line that where, for



1 a group, or a family, but a \$2,000.00 bill could very well
2 be, so that just on the basis of income alone it is very hard
3 to tell just what is burdensome or impossible and what is not.

4 What you did not suggest, you say that the needs
5 test is hard to administer but you did not suggest how you
6 organize or develop a needs test. Do you have any thoughts on
7 that or has that been given consideration?

8 DR. GOVAN: In Ontario, Mr. Chairman, the needs
9 test is being used by the Mothers and Dependents Allowance
10 Provisions so that there is some experience within Ontario
11 in the use of a needs test.

12 THE CHAIRMAN: You think that it is practical
13 on a large scale by service club organizations? Is this
14 practical on a large scale?

15 DR. GOVAN: I think it would be extremely
16 difficult and this again is why we suggest that there should
17 be subsidy or Government support rather than an individual
18 premium.

19 THE CHAIRMAN: Any further questions?

20 MISS CARPENTER: I wonder if we could ask, Mr.
21 Chairman, is this the type of needs test that is being used
22 in Toronto now in relation to requests for visiting nursing
23 service? Perhaps you don't know. As I understand it, groups
24 are being asked to fill in very long forms, take quite a long
25 time to do. They must be done in a group, or something. Again

DR. GOVAN: In Ontario, Mr. Chairman, the needs

What is the purpose of the study?

THE CHAIRMAN: Any further questions?



1 it is embarrassing to the individual so some individuals
2 will do without the service rather than have to answer these
3 questions so that you get back to the point of where the
4 voluntary agency is now trying to meet a need but can't meet
5 it because of the type of test they are being asked to
6 administer and also taking a great deal of their time.

7 DR. GOVAN: I am not familiar with the specific
8 test.

9 MISS CARPENTER: That is at least part of your
10 administrative problems?

11 DR. GOVAN: Yes, it is one of the problems.

12 THE CHAIRMAN: There does not appear to be any
13 further questions. Have you a further statement you would
14 like to make?

15 DR. GOVAN: I would like to thank the Committee
16 for their attention and for giving us the time to appear before
17 it. We are extremely appreciative of this.

18 THE CHAIRMAN: Thank you.

19
20 PRIVATE BRIEF OF MR. D.K. SUMMERHAYES DIRECTOR
21 OF THE CANADIAN CYSTIC FIBROSIS FOUNDATION.

22
23 THE CHAIRMAN: Have you had an opportunity to
24 read the statement on the table there?

25 MR. SUMMERHAYES: Yes.

DR. GOVAN: I am not familiar with the specific

test.

MISS CARPENTER: That is at least part of your

administrative problems?

DR. GOVAN: Yes, it is one of the problems.

THE CHAIRMAN: There does not appear to be any

further questions. Have you a further statement you would

like to make?

DR. GOVAN: I would like to thank the Committee

for their attention and for giving us the time to appear before

it. We are extremely appreciative of this.

THE CHAIRMAN: Thank you.

THE CHAIRMAN: Have you had an opportunity to

read the statement on the table there?

MR. SUMMERS: Yes.



1 THE CHAIRMAN: Are you alone Mr. Summerhayes?

2 MR. SUMMERHAYES: Yes, I am.

3 THE CHAIRMAN: Will you proceed then please?

4 MR. SUMMERHAYES: Mr. Chairman, members of the
5 Committee on Medical Health Services, I would like to clarify
6 that this brief has been presented not -- or at least was
7 originally presented not as a representative of the Canadian
8 Cystic Fibrosis Foundation but as a brief from a citizen
9 interested in medical health service in the Province. It has
10 since been considered, at least been submitted to the Associa-
11 tion or to the Foundation and is being considered for adoption
12 as our brief.

13 The reason for submitting it as a private citizen
14 is that I feel there has been a lack of any insurance coverage
15 for chronically ill persons. There is a definite need. It
16 was with a great deal of thought and after reading some of the
17 initial submissions to this Committee that I decided to submit
18 a brief and, therefore, I have not had, or did not have an
19 opportunity to contain it completely within the context of
20 Bill 163. I did not have a copy of Bill 163 at the time that
21 this was prepared so if I did wander a bit, I hope you will
22 bear with me.

23 I also want to make clear the fact that as a
24 businessman and in my own business and as a believer in the
25 free democratic society as opposed to a socialistic society,



THE CHAIRMAN: Are you alone Mr. Summerhayes?

MR. SUMMERHAYES: Yes, I am.

THE CHAIRMAN: Will you proceed then please?

MR. SUMMERHAYES: Mr. Chairman, members of the

Committee on Medical Health Services, I would like to clarify

that this brief has been presented not -- or at least was

originally presented not as a representative of the Canadian

Cystic Fibrosis Foundation but as a brief from a citizen

interested in medical health service in the Province. It has

since been considered, at least been submitted to the Associa-

tion or to the Foundation and is being considered for adoption

as our brief.

The reason for submitting it as a private citizen

for chronically ill persons. There is a definite need. It

was with a great deal of thought and after reading some of the

initial submissions to this Committee that I decided to submit

a brief and, therefore, I have not had, or did not have an

opportunity to contain it completely within the context of

I also want to make clear the fact that as a

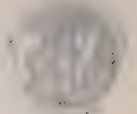
businessman and in my own business and as a believer in the



1 I do not believe that any health program should be paid out
2 of taxes. I believe it should be primarily, at least a major
3 portion should be paid out of contributions by the citizens
4 working in the Province. Those who are unemployed and are
5 indigent, as near as I have been able to find out in the last
6 five years that I have been connected with voluntary health
7 associations, receive fairly good basic medical assistance.

8 Relating it specifically to cystic fibrosis,
9 I know in several cases where inhalation therapy equipment has
10 been required, and drugs have been required and the children
11 have received total care, better care than those in the low
12 income bracket. For example, those in the \$50.00 a week income
13 bracket. I believe partially in what Dr. Govan said, that
14 there are medically indigent people who are earning a living
15 trying to hold their head high in the community trying to
16 provide for themselves but are being driven deeper and deeper
17 into debt because they have not got adequate medical health
18 insurance. Most of the private medical health plans, and I
19 say most, there are a few in recent years that have come out
20 on an individual basis, but most of the medical health
21 insurance plans that have been provided today have been
22 through group plans in industry provided by private insurance
23 companies. That is the type of insurance I feel is the best
24 for the people but this is not available to all of the people.

25 An example is that in many rural communities



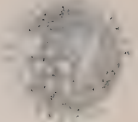
portion should be paid out of contributions by the citizens
 working in the Province. Those who are unemployed and are
 indigent, as near as I have been able to find out in the last
 five years that I have been connected with voluntary health
 associations, receive fairly good basic medical assistance.
 Referring to specifically to cystic fibrosis,
 I know in several cases where radiation therapy equipment has
 been supplied and where there have been payments for the
 treatment. In some cases, however, the cost has been
 income bracket. For example, those in the \$50.00 a week income
 bracket, I believe partially in what Dr. Govan said, that
 there are medically indigent people who are earning a living
 trying to hold their head high in the community trying to
 provide for themselves but are being driven deeper and deeper
 into debt because they have not got adequate medical health
 insurance. Most of the private medical health plans, and I
 say most, there are a few in recent years that have come out
 as an individual basis, but most of the medical health
 insurance plans that have been provided today have been
 through group plans in industry provided by private insurance
 companies. That is the type of insurance I feel is the best
 for the people but this is not available to all of the people.
 An example is that in many rural communities



1 individual farmers cannot get it unless they join into some
2 group and enter into a contract with private insurance
3 companies on a group basis or non-profit corporations, such
4 as P.S.I., Blue Cross, etcetera. Therefore, I believe that
5 Government must take a stand, and take a hand in medical
6 health insurance but I do want it clear that I believe it
7 should be on a contributory basis from earnings and kept
8 separate from the indigent through lack of income. I am
9 dealing primarily with the person who is working and earning
10 a living regardless of how meager it may be.

11 I am concerned with those who are willing to
12 help themselves and are trying to help themselves; not those
13 who are what you might call or I have heard called professional
14 charity cases. I think it is 6% of the population that is
15 constantly on welfare. These people, the children that I
16 have been connected with, have been fairly well cared for.

17 One other point I would like to make is that
18 a person earning \$6,000.00 a year, upwards of \$6,000.00 a
19 year, often can be a medical indigent because they may have
20 to spend two or three or even \$4,000.00 on medical care and
21 the only place they currently have to go for it is to the
22 voluntary agencies and oftentimes the voluntary agency takes
23 a look at their income and a home that they may have bought
24 before they became medically indigent, and say well they don't
25 need help. This happens in our community and other communities



individual farmers cannot get it unless they join into some
group and enter into a contract with private insurance
companies on a group basis or non-profit corporations, such
as P.S.I., Blue Cross, etcetera. Therefore, I believe that
Government must take a stand, and take a hand in medical
health insurance but I do want it clear that I believe it
separate from the indigent through lack of income. I am
dealing primarily with the person who is working and earning
a living regardless of how meager it may be.
I am concerned with those who are willing to
help themselves and are trying to help themselves; not those
who are what you might call or I have heard called professional
charity cases. I think it is 6% of the population that is
constantly on welfare. These people, the children that I
One other point I would like to make is that
a person earning \$5,000.00 a year, upwards of \$6,000.00 a
year, often can be a medical indigent because they may have
to spend two or three or even \$4,000.00 on medical care and
the only place they currently have to go for it is to the
voluntary agencies and oftentimes the voluntary agency takes
a look at their income and says that they may have brought
before they became medically indigent, and say well they don't
need help. This happens in our community and other communities



1 and in our society. I believe that any policing of a needs
2 test, medical needs test could be done, should be done by
3 the medical profession this being, I believe, one of the most
4 honourable professions in our country, in our society and I
5 think they could be relied on to police any medical needs test.

6 One other point of clarification is that because
7 this was submitted late, and rather hastily, I found a number
8 of typing errors in my original brief as submitted to this
9 Committee. I advised Mr. Turner that there is a revised brief,
10 not changing the content or anything of the brief, but merely
11 correcting the typing errors and adding words that were left
12 out in the original typing.

13 Very quickly I would like to go down and review
14 the brief. Appendix 1 is an outline, why the brief was
15 submitted.

16 Appendix 2 describes what Cystic Fibrosis is,
17 very quickly, and what the Canadian Cystic Fibrosis Foundation
18 has done since its inception in 1959 to help those afflicted.
19 The brief itself, paragraph A, item (a) equipment. The
20 equipment cost shown here of \$200.00 per unit -- this is on
21 page 5 of the brief -- is available at that cost only because
22 members of the Foundation have worked very hard in developing
23 new types of equipment that have been approved by the medical
24 profession and been able to reduce the cost.

25 One point I would like to make is that initially



1 and in our society. I believe that any policing of a needs
2 test, medical needs test could be done, should be done by
3 the medical profession this being, I believe, one of the most
4 honourable professions in our country, in our society and I
5 think they could be relied on to police any medical needs test.
6 One other point of clarification is that because
7 this was submitted late, and rather hastily, I found a number
8 of typing errors in my original brief as submitted to this
9 Committee. I advised Mr. Turner that there is a revised brief,
10 not changing the content or anything of the brief, but merely
11 correcting the typing errors and adding words that were left
12 out in the original brief.
13 Very quickly I would like to go down and review
14 the brief. Appendix I is an outline, why the brief was
15 submitted.
16 I would like to go down and review the brief, and what the Canadian Cystic Fibrosis Foundation
17 has done since its inception in 1959 to help those afflicted.
18 The brief itself, paragraph A, item (a) equipment. The
19 equipment cost shown here of \$200.00 per unit -- this is on
20 page 5 of the brief -- is available at that cost only because
21 members of the Foundation have worked very hard in developing
22 new types of equipment that have been approved by the medical
23 profession and been able to reduce the cost.
24 One point I would like to make is that initially



1 in purchasing this equipment it had to be brought in from the
2 United States and as an individual importing this equipment,
3 I would have to pay 22 and a half per cent duty, plus 11
4 per cent Federal Sales Tax because it is not considered in
5 the classification of oxygen equipment which uses compressed
6 air. This is aerosol equipment. It is basically the same type
7 of equipment. Looks very much the same but doesn't fit the
8 classification. Therefore, it was dutiable so for this reason
9 the Foundation imported this equipment and supplied it on a
10 donation basis. We somehow received relief from this by being
11 classified by the Federal Government as a hospital. I don't
12 know how we did it.

13 One other point is that this equipment, if
14 purchased by an individual, is not deductible from income as
15 a medical expense. Again, it does not fit the classification
16 of oxygen therapy equipment and therefore it isn't deductible.
17 The equipment, as I pointed out, would run considerably more
18 than \$300.00 if an individual wanted to purchase it directly
19 from a medical equipment supply house.

20 Now the next paragraph, paragraph (b) under
21 Drugs, I have come up with an estimate and this is one of the
22 errors in the original submission. The drug costs run anywhere
23 from \$50.00 to \$150.00 per patient and that should be per
24 month, with an average of \$75.00 to \$100.00 per patient per
25 month. Now this is definitely a low estimate because this is



417

I would have to pay 22 and a half per cent duty, plus 11 per cent Federal Sales Tax because it is not considered in the classification of oxygen equipment which uses compressed air. This is aerosol equipment. It is basically the same type of equipment. Looks very much the same but doesn't fit the classification. Therefore, it was dutiable so for this reason the Foundation imported this equipment and supplied it on a donation basis. We somehow received relief from this by being classified by the Federal Government as a hospital. I don't know how we did it.

One other point is that this equipment, if purchased by an individual, is not deductible from income as a medical expense. Again, it does not fit the classification of oxygen therapy equipment and therefore it isn't deductible. The equipment, as I pointed out, would run considerably more than \$300.00 if an individual wanted to purchase it directly from a medical equipment supply house.

Now the next paragraph, paragraph (b) under Drugs, I have come up with an estimate and this is one of the errors in the original submission. The drug costs run anywhere from \$50.00 to \$150.00 per patient and that should be per month, with an average of \$75.00 to \$100.00 per patient per month. Now this is definitely a low estimate because this is



1 based on our experience of purchasing these drugs for these
2 children at reduced costs from druggists, where they do not
3 take full mark-up or through wholesale houses that have made
4 a special arrangement with us. Taking it at the retail value,
5 these drugs often run as high as \$300.00 a month; an example
6 being with Staphcyllin, for aerosol use by face mask will cost
7 a family upwards of \$125.00 per month solely for that, plus
8 the other antibiotics, plus the digestive enzyme plus any other
9 medicine a child has to take so that you must add to that
10 \$125.00, at least another \$100.00 to \$125.00.

11 At the present time there are very few insurance
12 companies that will knowingly take a child or a family with
13 a child with a drug bill like this; not even in a group. I was
14 fortunate. I got into the first extended health benefit group
15 that P.S.I. had but I have since -- there is a limit of
16 \$4,000.00 in that -- I have since inquired from the insurance
17 companies and they will not knowingly take a group, particularly
18 a small group of people in with something of this nature. This
19 is what I am talking about, the medically indigent. A family
20 that is spending two or three thousand dollars a year on drugs
21 and equipment therapy, physical therapy is necessary. It is
22 vital to the welfare of the cystic fibrosis child. The periods
23 of therapy run from one to one and a half hours per day average
24 that the mother must spend giving physical therapy to each
25 child.



1 I have been thinking of writing you for some time but have been so busy that I have not had time to do so. I have been so busy that I have not had time to do so. I have been so busy that I have not had time to do so.

2 These things often run as high as \$300.00 a month; an example

3 being with Staphylococci, for aerosol use by face mask will cost

4 a family upwards of \$125.00 per month solely for that, plus

5 the other antibiotics, plus the digestive enzymes plus any other

6 medicine a child has to take so that you must add to that

7 \$125.00, at least another \$100.00 to \$125.00

8 At the present time there are very few insurance

9 companies that will knowingly take a child or a family with

10 a child with a drug bill like this; not even in a group. I was

11 fortunate. I got into the first extended health benefit group

12 that F.S.I. had but I have since -- there is a limit of

13 \$4,000.00 in that -- I have since incurred from the insurance

14 companies and they will not knowingly take a group, particularly

15 a small group of people in with something of this nature. This

16 is what I am talking about, the medically indigent. A family

17 that is spending two or three thousand dollars a year on drugs

18 and education therapy, physical therapy is necessary. It is

19 vital to the welfare of the cystic fibrosis child. The periods

20 of the child's life are so critical that it is almost impossible to

21 have a child with cystic fibrosis live a normal life. It is almost

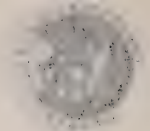
22 impossible to have a child with cystic fibrosis live a normal life.



1 If they have more than one, it is considerably
2 more. It is almost an impossible task for the mother if they
3 have more than one child. Now this has increased, this
4 amount of time is increased during periods of severe infection.
5 Therefore, oftentimes Victorian Order of Nurses, physiotherapist
6 or someone trained in this type of treatment must be brought
7 in from outside and must be paid.

8 Clinical treatment and assessment is vital to
9 the welfare of the child. They must attend clinics regularly
10 in order to assess the amount of lung damage they have and to
11 control it.

12 Homemaker-assistance. I feel this is something
13 that should be provided particularly in homes where there is
14 more than one afflicted child. The emotional strain on the
15 mother, particularly, of having to do the treatment, having
16 to pay for the unduly heavy cost of drugs, finding the money
17 and having to face the realistic truth that all of this at
18 the present time will not save her child, because her child
19 will pass away eventually, all the things she is giving up,
20 places a tremendous emotional strain on the mother if she
21 doesn't get away from it periodically for at least half a day
22 or a day a month. I know of several cases where the mother
23 has had a mental depression only because she couldn't face
24 the strain of the care and the fact that the child would
25 eventually pass away. There is also an emotional strain on



1 If they have more than one, it is considerably
2 more. It is almost an impossible task for the mother if they
3 have more than one child. Now this has increased, this
4 amount of time is increased during periods of severe infection.
5 Therefore, oftentimes Victorian Order of Nurses, physiotherapists
6 or someone trained in this type of treatment must be brought
7 in from outside and must be paid.
8
9 Clinical treatment and assessment is vital to
10 the welfare of the child. They must attend clinics regularly
11 in order to assess the amount of lung damage they have and to
12 control it.
13
14 I am sure, however, I feel this is something
15 that should be provided particularly in homes where there is
16 more than one afflicted child. The emotional strain on the
17 mother, particularly of having to do the treatment, having
18 to pay for the unduly heavy cost of drugs, finding the money
19 and having to face the realistic truth that all of this at
20 the present time will not save her child, because her child
21 will pass away eventually, all the things she is giving up,
22 places a tremendous emotional strain on the mother if she
23 doesn't get away from it periodically for at least half a day
24 or a day a month. I know of several cases where the mother
25 has had a mental depression only because she couldn't face
26 the strain of the care and the fact that the child would
27 eventually pass away. There is also an emotional strain on



1 the other members, the normal children in the family in that
2 the parents cannot spend the time with them, helping them with
3 homework and with their needs, their special needs and every
4 child, I believe, has special needs and needs special love and
5 attention, but the mother, the parents of a C.F. child cannot
6 spend this time and I think homemaker assistance should be
7 provided to ease this emotional stress.

8 I think I have covered pretty well the why's
9 which is in the next section of my brief. The only thing I
10 would like to point out here is that there are some children,
11 because of the excessive burden, are not getting total care;
12 that families are doing the best they can but they do not want
13 to enter into a means test and the Foundation, because of
14 limited funds, must have some form of a means test for supply-
15 ing drugs. We do supply drugs to some families. They struggle
16 along and as Dr. Govan said they cannot afford the drugs, they
17 go home and they don't get them.

18 The other thing is that under 4 of why is this
19 assistance required, I pointed out that some representation
20 should be made to the Federal Government for consideration of
21 travelling expenses for the people who must travel to clinics
22 such as in the case of cystic fibrosis children where they
23 go to a medical teaching centre for assessment. These are the
24 only places that currently qualified personnel are available
25 for assessment, and the equipment. But these expenses should

the other members, the normal children in the family in that the parents cannot spend the time with them, helping them with homework and with their needs, their special needs and every child, I believe, has special needs and needs special love and attention, but the mother, the parents of a C.F. child cannot spend this time and I think homemaker assistance should be provided to ease this emotional stress.

I think I have covered pretty well the why's which is in the next section of my paper. The only thing I would like to point out here is that there are some children, because of the extensive burden, and not getting total care; that families are doing the best they can but they do not want to enter into a mean test and the Foundation, because of limited funds, must have some form of a mean test for supplying drugs. We do supply drugs to some families. They struggle along and as Dr. Brown said they cannot afford the drugs, they go home and they don't get them.

The other thing is that under # of why is this assistance needed, I pointed out that some representation should be made to the Federal Government for consideration of travelling expenses for the people who must travel to clinics such as in the case of cystic fibrosis children where they go to a medical teaching centre for assessment. These are the only places that currently qualified personnel are available for assessment, and the equipment. But these expenses should



1 be deductible from income. I put that in not because I feel that
2 it should be covered by this Commission but possibly a
3 recommendation from this Commission to the Federal Government
4 might bear more weight than a small organization such as ours.
5 In the United States, I have to take my children to a clinic
6 in Cleveland and in the United States these expenses are
7 considered deductible medical expenses. They are scrutinized
8 by the Tax Department very carefully but they are considered
9 as a deductible expense.

10 Ladies and gentlemen, this is my brief. If
11 there are any questions, I would attempt to answer them.

12 THE CHAIRMAN: Thank you Mr. Summerhayes.
13 Mrs. McArthur?

14 MRS. MCARTHUR: Mr. Chairman, I would like to
15 confess to Mr. Summerhayes one convert to understanding a
16 problem that I had not really been too aware of before and I
17 did do some additional reading, which perhaps I would not have
18 done if I had not had the opportunity of reading your brief.
19 I think perhaps the key sentence in relation to this hearing
20 is in the last, the very last sentence of your brief, that this
21 whole problem should be reviewed in relation to any extension
22 of hospital insurance in Ontario. Thank you for taking this
23 opportunity of putting the problem before us. If at any time
24 a more comprehensive coverage could be considered, or if it
25 is considered, and I take it for granted that you see, in Bill

1 be deductible from income. I put that in not because I feel that
2 it should be covered by this Commission but possibly a
3 recommendation from this Commission to the Federal Government
4 might bear more weight than a small organization such as ours.
5 In the United States, I have to take my children to a clinic
6 in Cleveland and in the United States these expenses are
7 considered deductible medical expenses. They are scrutinized
8 by the Tax Department very carefully but they are considered
9 as a deductible expense.

10 Ladies and Gentlemen, this is my brief. If

11 there are any questions, I would attempt to answer them.

12 THE CHAIRMAN: Thank you Mr. Summerhayes.

13 Mrs. McArthur?

14 contrast to Mr. Summerhayes one convert to understanding a
15 problem that I had not really been too aware of before and I
16 did do some additional reading, which perhaps I would not have
17 done if I had not had the opportunity of reading your brief.
18 I think perhaps the key sentence in relation to this hearing
19 is in the last, the very last sentence of your brief, that this
20 whole problem should be reviewed in relation to any extension
21 of hospital insurance in Ontario. Thank you for taking this
22 opportunity of putting the problem before us. If at any time
23 a more comprehensive coverage could be considered, or if it
24 is considered, and I take it for granted that you see, in Bill



1 163, no limitations in relation to the medical care that would
2 be available -- am I correct in that statement?

3 MR. SUMMERHAYES: No. I would say that there
4 should be limitations but that the chronically ill person and
5 I dealt primarily with cystic fibrosis because this has been
6 where my experience mainly has been, there are other chronic
7 illnesses but I feel that in the case of the chronically ill,
8 where they cannot obtain, particularly where they cannot
9 obtain health insurance from private carriers, that they
10 should be embraced within this.

11 Now I would like to point out that one area
12 that I think would be a definite advantage to the present
13 Ontario Hospital Insurance Commission to include is the extension
14 of outpatient care in physiotherapy, in homemaker assistance
15 and things of this nature because right now when a child with
16 cystic fibrosis is taken ill with a severe lung infection, the
17 doctor is concerned with getting the best possible care for
18 that child. If there are two C.F. children at home, the mother
19 can't give it. They require specialized care so that he has
20 to hospitalize the child. This is not necessarily the best
21 thing for the child and it is not the least costly. The
22 least costly would be to have the physiotherapist go to the
23 home and give the child the physiotherapy treatments that are
24 required three or four times a day. It would mean three or
25 four trips but I believe would be less costly than putting the

1 193, no limitations in relation to the medical care that would
2 be available -- am I correct in that statement?
3 MR. SUMMERS: No. I would say that there
4 should be limitations but that the chronically ill person and
5 I dealt primarily with cystic fibrosis because this has been
6 where my experience mainly has been, there are other chronic
7 illnesses but I feel that in the case of the chronically ill,
8 where they cannot obtain, particularly where they cannot
9 obtain health insurance from private carriers, that they
10 should be embraced within this.
11 Now I would like to point out that one area
12 that I think would be a definite advantage to the present
13 Ontario Hospital Insurance Commission to include is the extension
14 of outpatient care in physiotherapy, in homecare assistance
15 and things of this nature because right now when a child with
16 cystic fibrosis is taken ill with a severe lung infection, the
17 doctor is concerned with getting the best possible care for
18 that child. If there are two C.F. children at home, the mother
19 can't give it. They require specialized care so that he has
20 to hospitalize the child. This is not necessarily the best
21 thing for the child and it is not the least costly. The
22 least costly would be to have the physiotherapist go to the
23 home and give the child the physiotherapy treatments that are
24 required three or four times a day. It would mean three or



1 child in hospital and paying the room and board and this is
2 the type of thing that I feel should be covered: Extension
3 to the extended care through outpatient care.

4 MRS. MCARTHUR: In other words, what you are
5 saying is in their first steps what is required is an
6 extension of the hospital insurance benefits rather than an
7 extension at the moment in Bill 163 for the payment of the
8 doctor to give service.

9 MR. SUMMERHAYES: Yes.

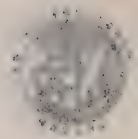
10 MRS. MCARTHUR: Which is provided.

11 MR. SUMMERHAYES: Definitely. I feel that the
12 payment of the doctor, and as I pointed out in the beginning
13 I haven't had an opportunity to review Bill 163 but in most
14 cases the working public is covered under group insurance
15 plans provided at their place of employment. It's the
16 extended health benefits, the real burdens in the form of
17 drugs and outpatient hospital care that I believe makes a
18 family medically indigent. In most cases you go to a doctor
19 and if you haven't got health insurance most doctors will give
20 care.

21 MRS. MCARTHUR: I think you made your point
22 quite clear there.

23 THE CHAIRMAN: Mr. Coulter?

24 MR. COULTER: I don't have too many questions,
25 Mr. Chairman. Mr. Summerhayes I too am a new convert. I



child in hospital and paying the room and board and this is the type of thing that I feel should be covered. Extension to the extended care through outpatient care.

MRS. MCARTHUR: In other words, what you are saying is in their first steps what is required is an extension of the hospital insurance benefits rather than an extension at the moment in Bill 163 for the payment of the doctor to give service.

MR. SUMMERHAYES: Yes.

MRS. MCARTHUR: Which is provided.

MR. SUMMERHAYES: Definitely I feel that the payment of the doctor, and as I pointed out in the beginning I haven't had an opportunity to review Bill 163 but in most cases the working public is covered under group insurance plans provided at their place of employment. It's the extended health benefits, the real burdens in the form of drugs and outpatient hospital care that I believe makes a family medically indigent. In most cases you go to a doctor and if you haven't got health insurance most doctors will give

MRS. MCARTHUR: I think you made your point

quite clear thank you.

MR. COULTER: I don't have too many questions. Mr. Chairman, Mr. Summerhayes I too am a new convert. I



1 never heard of it before until I got your brief; probably
2 unfortunate that I haven't. In your appendix 2 you say that
3 clinics are being set up in the various cities, and particularly
4 in Toronto, London and Ottawa. How are these clinics set up and
5 who sets them up?

6 MR. SUMMERHAYES: The clinics were set up by
7 the hospitals, the medical teaching hospitals.

8 MR. COULTER: Is this a request from your
9 foundation?

10 MR. SUMMERHAYES: They have come about frequently
11 because of the work the foundation has done. We have been
12 supporting them to some degree, but most of this is coming
13 from the hospitals. The only clinic in 1959, the only clinic
14 in Ontario was at Sick Children's Hospital, and it was run as
15 part of the general outpatient's clinic where the doctor
16 involved attended C.F. cases, as we call them on a certain day
17 every week because that was the day he supplied his services
18 to the clinic, but he had to see all cases came to the clinic
19 that day regardless of what they were. Now there are several
20 C.F. clinics in those three hospitals. I might point out
21 Kingston is in the process of setting up a clinic and one is
22 being considered for Hamilton.

23 MR. COULTER: That is my next question. We will
24 include Kingston and Hamilton, what about people living north
25 of Parry Sound.



1 never heard of it before until I got your brief; probably
2 unfortunate that I haven't. In your appendix 2 you say that
3 clinics are being set up in the various cities, and particularly
4 in Toronto, London and Ottawa. How are these clinics set up and
5 who sets them up?

6 MR. SUMMERHAYES: The clinics were set up by
7 the hospitals, the medical teaching hospitals.

8 MR. COULTER: Is this a request from your

9
10 MR. SUMMERHAYES: They have come about frequently
11 because of the work the foundation has done. We have been
12 supporting them to some degree, but most of this is coming
13 from the hospitals. The only clinic in 1959, the only clinic
14 in Ontario was at Sick Children's Hospital, and it was run as
15 part of the general outpatient's clinic where the doctor
16 involved attended C.F. cases, as we call them on a certain day
17 every week because that was the day he supplied his services
18 to the clinic, but he had to see all cases came to the clinic
19 that day regardless of what they were. Now there are several
20 C.F. clinics in those three hospitals. I might point out
21 Kingston is in the process of setting up a clinic and one is
22 being considered for Hamilton.

23 MR. COULTER: That is my next question. We will

24
25 of Parry Sound.



1 MR. SUMMERHAYES: They must travel to Toronto
2 or one of the other clinics. That is why I pointed out that.

3 MR. COULTER: Have you any information which
4 suggests there should be a clinic in Sudbury or Sault Ste.
5 Marie or Fort William.

6 MR. SUMMERHAYES: I cannot speak of Fort William
7 I don't know the exact number of cases out there. In Sudbury,
8 Timmins, areas north of North Bay we know of at least fifteen
9 children, and fifteen children would support the treatment
10 clinic one day a month.

11 MR. COULTER: How does your foundation raise its
12 funds at the moment.

13 MR. SUMMERHAYES: At the moment we raise our
14 funds only through voluntary donations from people who have
15 heard about us and know of children with Cystic Fibrosis and
16 we have conducted limited fund raising campaigns on a local
17 basis.

18 MR. COULTER: On page 6, section b the very
19 last line "this should be covered for clinics, either in
20 Ontario or other parts of Canada or outside Canada. I don't
21 think you mean this. It certainly wouldn't apply to Bill
22 163 or the Ontario Hospital Service Commission.

23 MR. SUMMERHAYES: Clinical assessment, as I
24 pointed out, it is available at the present time only in
25 certain limited areas. Now, some clinics are better equipped



1 MR. SUMMERHAYES: They must travel to Toronto
2 or one of the other clinics. That is why I pointed out that.
3 MR. COULTER: Have you any information which
4 suggests there should be a clinic in Sudbury or Sault Ste.
5 Marie or Fort William.
6 MR. SUMMERHAYES: I cannot speak of Fort William
7 I don't know the exact number of cases out there. In Sudbury,
8 Timmins, areas north of North Bay we know of at least fifteen
9 children, and fifteen children would support the treatment
10 clinic one day a month.
11 MR. COULTER: How does your foundation raise its
12 funds at the moment.
13 MR. SUMMERHAYES: At the moment we raise our
14 funds only through voluntary donations from people who have
15 heard about us and know of children with Cystic Fibrosis and
16 we have conducted limited fund raising campaigns on a local
17 basis.
18 MR. COULTER: On page 6, section b the very
19 last line "this should be covered for clinics, either in
20 Ontario or other parts of Canada or outside Canada. I don't
21 think you mean this. It certainly wouldn't apply to Bill
22 163 or the Ontario Hospital Service Commission.
23 MR. SUMMERHAYES: Clinical assessment, as I
24 pointed out it is available at the present time only in
25 certain limited areas. Now, some clinics are better equipped



1 and have a more experienced staff than other clinics. I
2 still believe in free choice, the democratic principle and I
3 think it should be paid, a person that wants to go to Cleveland,
4 such as I do, pay my subscription rate for health insurance to
5 cover this, should be paid on the basis of one of the Ontario
6 clinics. In other words if I go to Cleveland and I could go
7 to Toronto for \$5.00 a trip and in Cleveland it is \$10.00 I
8 feel I should be reimbursed to the extent of \$5.00.

9 MR. COULTER: You are saying to this Enquiry if
10 I live in Cochrane and I have a child afflicted with this and
11 I chose to go to Cleveland rather than to go to one say in
12 Sudbury or Sault Ste. Marie or Fort William that I have the
13 free choice at the taxpayers expense to take my child to
14 Cleveland?

15 MR. SUMMERHAYES: No. In the beginning I said
16 I didn't believe health insurance should be paid out of tax.
17 I think it should come out of contributions by people who work.

18 MR. COULTER: I think you mentioned later on the
19 last page, or some place, that travelling expenses should be
20 paid?

21 MR. SUMMERHAYES: No, I feel that representation
22 should be made to the Federal Government for travelling expenses
23 to be made deductible from income as a medical expense, not
24 that they should be paid.

25 MR. COULTER: How about a person that was



1 and have a more experienced staff than other clinics. I

2 still believe in free choice, the democratic principle and I

3 think it should be paid, a person that wants to go to Cleveland

4 even so, pay my subscription rate for health insurance to

5 cover this, should be paid on the basis of one of the Ontario

6 clinics. In other words if I go to Cleveland and I could go

7 to Toronto for \$5.00 a trip and in Cleveland it is \$10.00 I

8 feel I should be reimbursed to the extent of \$5.00.

9 MR. COULTER: You are saying to this Inquiry if

10 I live in Cochrane and I have a child afflicted with this and

11 I chose to go to Cleveland rather than to go to one say in

12 Sudbury or Sault Ste. Marie or Fort William that I have the

13 free choice at the taxpayers expense to take my child to

14 Cleveland?

15 MR. SUMMERHAYES: No. In the beginning I said

16 I don't believe health insurance should be paid out of tax.

17 I think it should come out of contributions by people who work

18 MR. COULTER: I think you mentioned later on the

19 last year, that these clinics, that travelling expenses should be

20 paid.

21 MR. SUMMERHAYES: No, I feel that representation

22 should be made to the federal government for travelling expenses

23 so as not to deduct from income as a medical expense, not

24 that they should be paid.

25 MR. COULTER: How about a person that was



1 indigent or unable to pay.

2 MR. SUMMERHAYES: Then they should attend, the
3 children should attend the nearest clinic, and I believe this
4 is where the voluntary agencies should then step in to provide
5 the travelling expenses for the indigent to the nearest clinic.
6 If I choose as an individual to pay the expenses to go to
7 Cleveland or Toronto, to what I consider to be the best clinic,
8 then I think I should have a choice and only be reimbursed on
9 the going tariff, the tariff set by the Commission.

10 THE CHAIRMAN: Dr. Galloway.

11 DR. GALLOWAY: I am sure Mr. Summerhayes has
12 recognized the sympathy we all have for this cause. I
13 recognize the tremendous public relations job they have been
14 doing. After listening to him I can appreciate that. I
15 would almost like to help you by questions. Can you tell me
16 what the effect of hereditary and environment has.

17 MR. SUMMERHAYES: Cystic Fibrosis is hereditary
18 and according to the statistics available it occurs in one in
19 every one thousand live births. They are considered to be,
20 and I have to put it this way, because in Canada we haven't
21 actual statistics, the Health Department haven't gathered any
22 and we are going by American Statistics, but I believe it
23 applies, that there is considered to be a trait in every 30 to
24 50 adults in the population. These adults must unite in
25 marriage and each must carry the trait in order to produce a



children should attend the nearest clinic, and I believe this
is where the voluntary agencies should then step in to provide
the travelling expenses for the indigent to the nearest clinic.
If I choose as an individual to pay the expenses to go to
Cleveland or Toronto, so what I consider to be the best clinic,
the going tariff, the tariff set by the Commission.

DR. GALLOWAY: I am sure Mr. Summerhayes has
recognized the sympathy we all have for this cause. I
recognize the tremendous public relations job they have been
doing. After listening to him I can appreciate that. I
would almost like to see a photograph of him and
what the effect of hereditary and environment has.

MR. SUMMERHAYES: Cystic Fibrosis is hereditary
and according to the statistics available it occurs in one in
every one thousand live births. They are considered to be,
and I have to put it this way, because in Canada we haven't
actual statistics, the Health Department haven't gathered any
and we are going by American Statistics, but I believe it
applies, that there is considered to be a trait in every 30 to
50 adults in the population. These adults must unite in
marriage to produce a child with the disease.



1 C.F. offspring. Does that answer the question?

2 DR. GALLOWAY: That answers the first part.

3 Does environment play a part?

4 MR. SUMMERHAYES: Environment, no, not in general
5 knowledge at the present time. Environment would definitely
6 play a part to the well being of the child, the C.F. child
7 whose parents were in an environment where they didn't get the
8 proper care, but it doesn't play any part in the production of
9 the C.F. child.

10 DR. GALLOWAY: With the increasing number of
11 diagnosis that are being made of this disease, it is a question
12 of increasing the number of children surviving for a certain
13 number of years. Some years ago polio was such a dreadful scare
14 a number of insurance companies established an actual polio
15 insurance one could buy for a reasonable sum for a three year
16 period. Has your organization ever thought of selling such
17 an insurance program?

18 MR. SUMMERHAYES: No, we didn't. We operate
19 without much in the way of paid staff. We actually hired the
20 services from the Canadian Council for Crippled Children, and
21 this has never been considered, mainly because of the work
22 involved and the fact that incidence is so high that it would
23 be difficult to find a carrier to carry the burden for a
24 limited group. I feel it should be spread over a much broader
25 group than just the groups we would find here.



DR. GALLOWAY: That answers the first part.

Does environment play a part?

MR. SUMMERHAVER: Environment, no, not in general.

Knowledge at the present time, Environment would definitely

whose parents were in an environment where they didn't get the proper care, but it doesn't play any part in the production of

DR. GALLOWAY: With the increasing number of

diagnoses that are being made of this disease, it is a question

of increasing the number of children surviving for a certain

number of years. Some years ago polio was such a dreadful scourge

a number of insurance companies established an actual polio

insurance one could pay for a reasonable sum for a three year

period. Has your organization ever thought of selling such

an insurance program?

MR. SUMMERHAVER: No, we didn't. We operate

without much in the way of paid staff. We actually hired the

services from the Canadian Council for Gifted Children, and

this has never been considered, mainly because of the work

involved and the fact that incidence is so high that it would

be difficult to find a carrier to carry the burden for a

limited group. I feel it should be spread over a much broader

group than just the groups we would find here.



1 DR. GALLOWAY: You mentioned one in a thousand
2 births developed a child with this disease. Have you any idea
3 of the number of births in Ontario per annum.

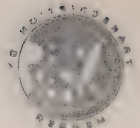
4 MR. SUMMERHAYES: I haven't the figures, the
5 recent figures in front of me on the number of births in
6 Ontario, but I do know that we have upwards, we know of up-
7 wards of a thousand cases of Cystic Fibrosis now, and we know
8 that not by any means have all the cases of Cystic
9 Fibrosis been diagnosed. We had one case brought in recently
10 when the child was twelve and it was just then diagnosed.
11 This was unusual, but they will survive that long without
12 proper treatment.

13 DR. GALLOWAY: Thank you very much.

14 THE CHAIRMAN: Can you reconcile these figures
15 for me. You say you know of a thousand cases and you say
16 there are 200 to 250 children under treatment. Do you mean
17 the rest are not under treatment?

18 MR. SUMMERHAYES: So far as the children under
19 treatment, these are under treatment in the medical centres.
20 There are many who are presently attending the clinic for
21 regular assessment. They have been diagnosed. They have gone
22 back to their homes and are being treated by their own family
23 physicians and not coming back to regular assessment.

24 THE CHAIRMAN: Is this because that type of
25 treatment is satisfactory in their particular case or because



1 DR. GALLOWAY: You mentioned one in a thousand
2 births developed a child with this disease. Have you any idea
3 of the number of births in Ontario per annum.
4 MR. SUMMERHAYES: I haven't the figures, the
5 recent figures in front of me on the number of births in
6 Ontario, but I do know that we have upwards, we know of up-
7 wards of a thousand cases of Cystic Fibrosis now, and we know
8 that not by any means have all the cases of Cystic
9 Fibrosis been diagnosed. We had one case brought in recently
10 when the child was twelve and it was just then diagnosed.
11 This was unusual, but they will survive that long without
12 any treatment.
13 DR. GALLOWAY: Thank you very much.
14 THE CHAIRMAN: Can you reconcile these figures
15 for me. You say you know of a thousand cases and you say
16 there are 200 to 250 children under treatment. Do you mean
17 the rest are not under treatment?
18 MR. SUMMERHAYES: So far as the children under
19 treatment, these are under treatment in the medical centres.
20 There are many who are presently attending the clinic for
21 treatment, they have been diagnosed. They have been
22 back to their homes and are being treated by their own family
23 physicians and not coming back to regular assessment.
24 THE CHAIRMAN: Is this because that type of
25 treatment is satisfactory in their particular case or because



1 they are unable to afford it.

2 MR. SUMMERHAYES: It is primarily because of
3 the cost burden of drugs and equipment, homemaker assistance,
4 physiotherapy care, that they can't afford to travel back
5 and forth, primarily because of that, for that reason.

6 THE CHAIRMAN: It would seem to me that is a
7 very serious consideration for your Foundation.

8 MR. SUMMERHAYES: This is true, but at the
9 present time we are \$33,000.00 in the red.

10 THE CHAIRMAN: I mean a serious consideration
11 whether you are able to cope with it or not.

12 MR. SUMMERHAYES: It is. The Foundation is
13 trying to encourage hospitals to make at least treatment
14 centres, if not assessment centres, have good research
15 centres available. We are trying to make treatment centres
16 available in a much broader area of the Province, but we must
17 receive assistance from the hospitals, the medical profession,
18 the Department of Health and other voluntary agencies, and
19 these are pretty difficult groups, sometimes to bring together.

20 MR. NAYLOR: I think my questions have been
21 largely answered, but I was curious to know, Mr. Summerhayes,
22 if the traits which certain adults have to transmit the
23 disease to children may be diagnosed.

24 MR. SUMMERHAYES: No, it can't. At the present
25 time it can only be discovered because they produce the C.F.



MR. SUMMERHAYES: It is primarily because of the cost burden of drugs and equipment, homemaker assistance, transportation, and the like, that the program is not more widespread.

THE CHAIRMAN: It would seem to me that is a

MR. SUMMERHAYES: This is true, but at the present time we are \$33,000.00 in the red.

whether you are able to cope with it or not.

MR. SUMMERHAYES: It is. The Foundation is trying to encourage hospitals to make at least treatment centers, if not assessment centers, have good research centers available. We are trying to make treatment centers available in a much broader area of the Province, but we must receive assistance from the hospitals, the medical profession, the Department of Health and other voluntary agencies, and these are pretty difficult groups, sometimes to bring together.

MR. SUMMERHAYES: I was anxious to know, Mr. Summerhayes, if the results which certain adults have to transmit the disease to children may be diagnosed.

MR. SUMMERHAYES: No, it can't. At the present time it can only be discovered because they produce the C.F.



1 offspring. One thing I should point out is you can have two
2 people with the C.F. trait marry and not produce C.F.
3 offspring because chances are one in four of having a C.F.
4 child.

5 DR. BUTT: Genetically it is known as the
6 recessive gene.

7 MR. SUMMERHAYES: The other thing if one adult
8 has the C.F. trait that this trait would be passed on so it
9 could crop up several generations later.

10 MR. NAYLOR: That is all.

11 THE CHAIRMAN: Dr. Butt.

12 DR. BUTT: I have nothing more about your
13 brief but I think this might be of assistance, and I am sure
14 the Western Hospital will not appreciate my saying this but
15 the Hospital initiated a home care program. There is one
16 at Western and one at Mount Sinai, provided you can get in
17 you can get home care provided up to sixty days and additional
18 days of care will be provided where there is evidence of
19 necessity. Home care provides for nursing visits, physical
20 and occupational therapy, all necessary laboratory tests,
21 x-ray study, drugs, medicines and dressings and all hospital
22 or sickroom equipment needed. Maybe there is one answer.

23 MR. SUMMERHAYES: You say it is sixty days?

24 DR. BUTT: Additional days of care will be
25 provided where there is evidence of necessity.

people with the C.F. trait marry and not produce C.F.
offspring because chances are one in four of having a C.F.
child.

DR. BUTT: Genetically it is known as the

recessive gene.

MR. SUMMERHAYES: The other thing if one adult

has the C.F. trait that this trait would be passed on so it

could crop up several generations later.

MR. WATSON: That is all.

DR. BUTT: I have nothing more about your

brief but I think this might be of assistance, and I am sure

the Western Hospital will not appreciate my saying this but

the Hospital initiated a home care program. There is one

at Western and one at Mount Sinai, provided you can get in

You can get home care provided up to sixty days and additional

days of care will be provided where there is evidence of

and occupational therapy, all necessary laboratory tests,

x-ray study, drugs, medicines and dressings and all hospital

or sickroom equipment needed. Maybe there is one answer.

MR. SUMMERHAYES: You say it is sixty days?

DR. BUTT: Additional days of care will be

provided where there is evidence of necessity.



1 MR. SUMMERHAYES: How long would that go on?

2 DR. BUTT: I have no idea. Here it is.

3 MR. SUMMERHAYES: We have been trying to get
4 some similar provision for Sick Children's.

5 MR. BUTT: Here is one. It was established
6 since 1961, 1961. Maybe you could investigate. I am sure
7 that the hospital wouldn't appreciate me telling you.

8 MR. SUMMERHAYES: Thank you very much. I
9 appreciate that.

10 THE CHAIRMAN: Any further questions?

11 MR. CASWELL: May I just ask Mr. Summerhayes
12 does your Cystic Fibrosis Association endeavour to assist
13 all these thousand cases with the things which you purchase
14 and have and which are necessary to them or just the two
15 hundred or two hundred and fifty who attend the clinics.

16 MR. SUMMERHAYES: I would say our equipment is
17 given out to probably around 250 or possibly 300. We will
18 provide it to anyone, any person who requests it. Many of
19 these haven't requested, and there are some doctors in the
20 medical profession who don't necessarily agree that this is
21 the best treatment. The clinics in North America, they
22 consider it the best treatment, but each doctor can decide
23 for himself and some doctors don't ask their patients to
24 request these because they feel they can provide the necessary
25 care in other ways. We now have in Ontario, I would estimate



MR. SUMMERHAYES: How long would that go on?

DR. BUTT: I have no idea. Here it is.

MR. SUMMERHAYES: We have been trying to get

some similar provision for Sick Children's.

MR. BUTT: Here is one. It was established

since 1961, 1962. Maybe you could investigate. I am sure

that the hospital wouldn't appreciate me telling you.

MR. SUMMERHAYES: Thank you very much. I

appreciate that.

THE CHAIRMAN: Any further questions?

MR. CASWELL: May I just ask Mr. Summerhayes

does your Cystic Fibrosis Association endeavour to assist

all these thousand cases with the things which you purchase

and have and which are necessary to them or just the two

hundred or two hundred and fifty who attend the clinics.

MR. SUMMERHAYES: I would say our equipment is

given out to probably around 250 or possibly 300. We will

provide it to anyone, any person who requests it. Many of

these haven't requested, and there are some doctors in the

medical profession who don't necessarily agree that this is

the best treatment. The clinics in North America, they

consider it the best treatment, but each doctor can decide

for himself and some doctors don't ask their patients to

request more equipment. They feel that they are providing the best

care in their area. We are in a position, I would estimate



1 around 300 tents.

2 MR. CASWELL: Thank you, Mr. Chairman.

3 MR. SIMON: Mr. Chairman, one thing on Bill 163
4 for medical benefits. The patients would be able to pay
5 insurance and no carrier would be able to refuse them insurance
6 under this Bill. If I may be permitted one more comment, Mr.
7 Chairman, you have referred several times, you made statements
8 that you are against Government subsidization and so on and
9 then your last request is that the Ontario Hospital Commission
10 assume the responsibility for these patients. Don't you think
11 that these are Government subsidies?

12 MR. SUMMERHAYES: I am not asking them to assume
13 the responsibilities. I believe the responsibility should
14 remain with the parent and that the parent should accept the
15 responsibility. I am asking that the Ontario Hospital Services
16 Commission provide, as you say Bill 163 will provide, that
17 the insurance could be made available for these families to
18 assist them in their supply of drugs and equipment. I am not
19 asking for, and the last thing I would want as a business man
20 and, as I said, a believer in free democratic society, the last
21 thing I would want is that the individuals receive total
22 assistance from the Government because I believe this takes
23 away the initiative from the individual.

24 MR. CASWELL: I didn't mention one thing, the
25 Bill, and perhaps Mr. Summerhayes doesn't know at the moment,



Ground 300 tents.

MR. SIMON: Mr. Chairman, one thing on Bill 163

for medical benefits. The patients would be able to pay

under this Bill. If I may be permitted one more comment, Mr.

that these are Government subsidies?

MR. SUMMERHAYES: I am not asking them to assume

the responsibilities. I believe the responsibility should

remain with the parent and that the parent should accept the

responsibility. I am asking that the Ontario Hospital Services

Commission provide, as you say Bill 163 will provide, that

the insurance could be made available for these families to

assist them in their supply of drugs and equipment. I am not

asking for, and the last thing I would want as a business man

and, as I said, a believer in free democratic society, the last

thing I would want is that the individuals receive total

assistance from the Government because I believe this takes

away the initiative from the individual.

MR. CASWELL: I didn't mention one thing, the

Bill, and perhaps Mr. Summerhayes doesn't know at the moment.



1 doesn't take in drugs and equipment. For the C.F., drugs and
2 equipment is a heavy expense. It is going to cover medical,
3 but the greater part of the payment with the C.F. child is the
4 cost of drugs and equipment. If help is to be given this is
5 where it should be given.

6 THE CHAIRMAN: Any further comments or questions?

7 MR. MAJOR: Could I ask just one question. Mr.
8 Summerhayes, you mentioned you had some coverage from P.S.I.

9 MR. SUMMERHAYES: Yes.

10 MR. MAJOR: Is that you, personally?

11 MR. SUMMERHAYES: Yes.

12 MR. MAJOR: Do you know of any C.F. people that
13 have coverage through P.S.I.?

14 MR. SUMMERHAYES: Yes, there are a few.

15 MR. MAJOR: Do they have extended health benefits?

16 MR. SUMMERHAYES: There are very few with
17 extended health benefits. It is a limited plan just brought
18 out two years ago on an experimental basis. Our group was very
19 fortunate that we were one of the first selected. We were
20 selected as a small group as an experiment for this extended
21 health benefit. There are not too many firms that do carry it.

22 MR. MAJOR: What I was going to ask was P.S.I.'s
23 extended health benefit plan covers drugs, physiotherapy and
24 appliances, and I imagine that the tent you are talking about
25 would be covered. Do you know of anybody that has got benefits



434

1 doesn't take in drugs and equipment. For the C.F. group and
2 equipment is a heavy expense. It is going to cost a lot of money.
3 but the greater part of the payment with the C.F. child is the
4 cost of drugs and equipment. If help is to be given this is
5 where it should be given.
6 THE CHAIRMAN: Any further comments or questions?
7 MR. MAJOR: Could I ask just one question, Mr.
8 Summerhayes, you mentioned you had some coverage from P.S.I.
9 MR. SUMMERHAYES: Yes.
10 MR. MAJOR: Is that what you mean?
11 MR. SUMMERHAYES: Yes.
12 MR. MAJOR: Do you know of any C.F. people that
13 have coverage through P.S.I.?
14 MR. SUMMERHAYES: Yes, there are a few.
15 MR. MAJOR: Do they have extended health benefits?
16 MR. SUMMERHAYES: Yes, they do.
17 extended health benefits. It is a limited plan just brought
18 out two years ago on an experimental basis. Our group was very
19 fortunate that we were one of the first selected. We were
20 selected as a small group as an experiment for this extended
21 health benefit. There are not too many firms that do carry it.
22 MR. MAJOR: What I was going to ask was P.S.I.'s
23 extended health benefit plan covers drugs, physiotherapy and
24 appliances, and I imagine that the tent you are talking about
25 would be covered. Do you know of anybody that has got benefits



1 on a C.F. basis for this?

2 MR. SUMMERHAYES: As I say I have benefited
3 personally from this, but I might point out that their limit
4 is \$4,000.00 and you will reach that in about three to four
5 years.

6 MR. MAJOR: Isn't there a clause that says after
7 expenditures of \$1,000.00 you can raise your maximum.

8 MR. SUMMERHAYES: Only if the illness is consider-
9 ed arrested or cured and then you can apply for additional
10 benefit.

11 MR. MAJOR: I think you should write and ascertain
12 that.

13 MR. SUMMERHAYES: I have been to see them.

14 MR. CASWELL: I think it is fair for Mr.
15 Summerhayes to know that Mr. Major is General Manager of P.S.I.
16 and he is sympathetic to you. I think you should call on them
17 and what he tells us could be to your benefit.

18 MR. SUMMERHAYES: What was the name again?

19 MR. CASWELL: Mr. Major. I am most sympathetic
20 and I think you should follow it through.

21 MR. NAYLOR: I would also inform you there are
22 a number of insurance companies that will sell group plans
23 which would cover these expenses under major medical or
24 comprehensive type of plans. They would cover groups, perhaps,
25 over 25, and maybe below that level.

over 25, and maybe below that level.

comprehensive type of plans. They would cover groups, perhaps,

which would cover these expenses under major medical or

a number of insurance companies that will sell group plans

MR. NAYLOR: I would also inform you there are

and I think you should follow it through.

MR. GARDNER: Mr. Major, I am most sympathetic

MR. SUMMERHAYES: What was the name again?

and what he tells us could be to your benefit.

and he is sympathetic to you. I think you should call on them

Summerhayes to know that Mr. Major is General Manager of R.S.I.

MR. GARDNER: I think it is fair for Mr.

MR. SUMMERHAYES: I have been to see them.

MR. MAJOR: I think you should write and ascertain

benefit.

ed arrested or cured and then you can apply for additional

MR. SUMMERHAYES: Only if the illness is considered

expenditures of \$1,000.00 you can raise your maximum.

MR. MAJOR: Isn't there a clause that says after

years.

is \$4,000.00 and you will reach that in about three to four

personally from this, but I might point out that their limit

As I say I have benefited



1 MR. SUMMERHAYES: Our firm has 50 employees and
2 I have been turned down by two companies. The third company
3 after they heard about it didn't come back and the fourth
4 company said they will consider it, but they have refused.

5 MR. NAYLOR: I think you should apply without
6 telling them. You are not obligated to tell them.

7 MR. SUMMERHAYES: That is not my nature. I
8 will take your suggestion and see Mr. Major.

9 THE CHAIRMAN: Mr. Summerhayes I think that the
10 questions of the members of the Enquiry and the comments which
11 have been made by the members of the Enquiry indicate that they
12 are entirely sympathetic to your problems here. I believe you
13 have done a great deal to enlighten many of us who weren't
14 familiar with these problems. I hope that some of the
15 publicity that may appear as a result of this may be also
16 helpful to your Foundation in bringing forward the great need
17 that does exist on the part of these families who are afflicted
18 with this unfortunate disease. Personally I wish to congrat-
19 ulate you on the effort that you have put forward in your
20 presentation .

21 MR. SUMMERHAYES: Thank you, Dr. Hagey, Ladies
22 and Gentlemen. Thank you very much for the opportunity of
23 appearing.

24 THE CHAIRMAN: We will adjourn to 2:15.

25 ---Luncheon Adjournment.



Our firm has 50 employees and
I have been turned down by two companies. The third company
after they heard about it didn't come back and the fourth
company said they will consider it, but they have refused.
MR. MAYOR: I think you should apply without
telling them. You are not obligated to tell them.
That is not my nature. I
will take your suggestion and see Mr. Mayor.
THE CHAIRMAN: Mr. Summerhayes I think that the
questions of the members of the Board and the comments which
have been made by the members of the Board indicate that they
are entirely sympathetic to your problems here. I believe you
have done a great deal to enlighten many of us who weren't
familiar with these problems. I hope that some of the
publicity that may appear as a result of this may be also
helpful to your Foundation in bringing toward the great need
that does exist on the part of these families who are afflicted
with this unfortunate disease. Personally I wish to congrat-
ulate you on the effort that you have put forward in your
presentation.
and Gentlemen. Thank you very much for the opportunity of
appearing.
THE CHAIRMAN: We will adjourn to 2:15.
---Incheon Adjournment.



1 ---On resuming at 2:15 p.m.

3 SUBMISSION BY THE ONTARIO PSYCHIATRIC ASSOCIATION

4 Appearances: Dr. R. Chalke,
5 Dr. A. Miller,
6 Dr. H.C. Moorhouse,
7 Dr. J.D. Atcheson,
8 Dr. H.W. Henderson,
9 Dr. K.G. Gray.

10 THE CHAIRMAN: Ladies and gentlemen, I assume
11 that the group in front of us is the delegation from the
12 Ontario Psychiatric Association. I presume you have had an
13 opportunity to read the statement on instructions have you?

14 DR. CHALKE: Yes.

15 THE CHAIRMAN: Then is it Dr. Chalke who is the
16 spokesman?

17 DR. MILLER: As Chairman of the Ontario
18 Psychiatric Association I wonder if I might introduce Dr.
19 Chalke?

20 THE CHAIRMAN: Certainly.

21 DR. MILLER: First of all, the Ontario
22 Psychiatric Association is gratified at this opportunity to
23 meet with the Commission sir and this Committee, which represents
24 275 physicians practicing psychiatry and who are members of
25 the Ontario Psychiatric Association has prepared this brief,
which you have before you, because this organization considers



---on resuming at 2:15 p.m.

REPORT OF THE COMMITTEE ON THE PSYCHIATRIC ASSOCIATION

- Dr. K.G. Gray.
- Dr. H.C. Moorhouse.
- Dr. J. A. Miller.
- Dr. J. A. Miller.
- Dr. J. A. Miller.

THE CHAIRMAN: Ladies and gentlemen, I assume

that the group in front of us is the delegation from the Ontario Psychiatric Association. I presume you have had an opportunity to read the statement on instructions have you?

THE CHAIRMAN: Then is it Dr. Chaikie who is the

spokesman?

DR. MILLER: As Chairman of the Ontario Psychiatric Association I wonder if I might introduce Dr.

Chaikie?

DR. MILLER: First of all, the Ontario

Psychiatric Association is gratified at this opportunity to

275 physicians practicing psychiatry and who are members of

the Ontario Psychiatric Association and I am pleased to have

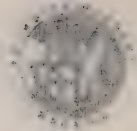
which you have before you, because this organization has been



1 it essential, at this stage of medical history in Ontario, any
2 plan providing care for people with health problems must include
3 provision for the care, of the same standard, of psychiatric
4 disability. This is considered essential not only because of
5 the large numbers of people suffering from a variety of
6 psychiatric disorders, which are recently estimated to be
7 15 thousand annual admissions to psychiatric hospitals, about
8 25 thousand patients treated in non psychiatric hospitals,
9 such as community and mental health clinics, and the estimated
10 figure of at least 10% of medical problems treated by general
11 practitioners, but because of the clear evidence that psychiat-
12 ric treatment has proven its effectiveness in many of the
13 psychiatric problems that people have and that the considerable
14 increase in psychiatrists and psychiatric personnel has
15 reflected this trend I mentioned a moment ago and, therefore,
16 has made the needed therapy possible.

17 The tremendous increase in the understanding
18 of psychiatric illness and the growth of more effective
19 therapeutic methods has been reflected in a great expansion of
20 psychiatric teaching in the medical schools, which are estimated
21 to be 500% over that of 1945, and this has equipped the
22 graduating doctor with a greater skill in recognizing and
23 treating psychiatric disorders and, consequently, is being
24 used a great deal more than 15, 20 years ago.

25 Therefore, it can be said although humanitarian



1 It is noteworthy that this change in medical education is reflected in the
2 first professional year of the medical curriculum, which is now devoted to
3 psychiatry for the first time. This is a significant development in the
4 curriculum. This is a significant development in the curriculum.
5 the large numbers of people suffering from a variety of
6 psychiatric disorders, which are generally admitted to
7 15 thousand annual admissions to psychiatric hospitals, about
8 25 thousand patients treated in non-psychiatric hospitals,
9 such as community and mental health clinics, and the estimated
10 figure of at least 10% of medical problems treated by general
11 practitioners, but because of the clear evidence that psychia-
12 tric treatment has proven its effectiveness in many of the
13 psychiatric problems that people have and that the considerable
14 increase in psychiatrists and psychiatric personnel has
15 reflected this trend I mentioned a moment ago and, therefore,
16 has made the needed therapy possible.
17 The tremendous increase in the understanding
18 of psychiatric illness and the growth of new approaches
19 therapeutic methods has been reflected in a great expansion of
20 psychiatric teaching in the medical schools, which are estimated
21 to be 500% over that of 1945, and this has equipped the
22 graduating doctor with a greater skill in recognizing and
23 treating psychiatric disorders and, consequently, is being
24 used a great deal more than 15, 20 years ago.
25 Therefore, it can be said although humanitarian



1 reasons for providing treatment of sick people are important,
2 the practical issue behind the brief is that modern methods
3 of treatment in psychiatry have shown their effectiveness
4 beyond any doubt. For this reason this Association considers
5 that it must become available to anyone in this Province who
6 requires it and, therefore, it should be available under the
7 operating conditions of a health plan.

8 Now the Committee, which has set up the brief
9 which you have before you, was chaired by Dr. Chalke, who is
10 to my left, and he will be the main spokesman.

11 At this particular time I would like to introduce
12 the members of this Committee. Starting on my right, Dr. Ken
13 Gray, who is our Counsel. Dr. H.W. Henderson, who is Secretary
14 of the Ontario Psychiatric Association. Dr. J.D. Atcheson on
15 my left who is the President-elect of the Ontario Psychiatric
16 Association. Dr. H.C. Moorhouse next to him, who is the
17 Secretary of the Committee who prepared this brief, and then
18 Dr. Chalke who will be the spokesman for this group.

19 DR. CHALKE: Mr. Chairman, I might take five
20 minutes to just draw attention to some of the things we feel
21 are rather important. I am not going to review with you the
22 history of psychiatry and treatment in psychiatry, because I
23 am sure the members of the Commission know two patterns have
24 developed in psychiatry and are now treated in two ways.
25 Psychiatric illness patients are now cared for in two different

1. ... for providing ...
 2. ...
 3. ...
 4. beyond any doubt. For this reason this Association considers
 5. that it must become available to anyone in this province who
 6. requires it and, therefore, it must be available within the
 7. operating conditions of a health plan.

8. Now the Committee, which has set up the brief

9. which you have before you, has asked Dr. Chaikie, who is
 10. to my left, and he will be the main spokesman.

11. At this particular time I would like to introduce

12. the members of this Committee. Starting on my right, Dr. Ken
 13. Gray, who is our Counsel. Dr. H.W. Henderson, who is Secretary
 14. of the Ontario Psychiatric Association. Dr. J.D. Atchison on
 15. my left who is the President-elect of the Ontario Psychiatric
 16. Association. Dr. H.C. Macdonald next to him, who is the
 17. Secretary of the Committee who prepared this brief, and then
 18. Dr. Chaikie who will be the spokesman for this group.

19. DR. CHAIKIE: Mr. Chairman, I might take five

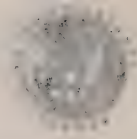
20. minutes to just draw attention to some of the things we feel
 21. are rather important. I am not going to review with you the
 22. history of psychiatry and treatment in psychiatry, because I
 23. am sure the members of the Commission know two patterns have
 24. developed in psychiatry and are now treated in two ways.

25. Psychiatric illness patients are now cared for in two different



1 ways, as a result of accident of history, unlike other forms
2 of illness. This is damaging to the treatment and damaging
3 to the patient as people working in this field have become
4 aware over the last few years and every responsible medical
5 body in this country, including general medicine and psychiatry,
6 and lay organizations have all been expressing the opinion,
7 backed up by some good evidence, mental illness should be
8 treated on the same basis as any other illness. As has been
9 said, this is an axiom from which we can proceed.

10 Now this is beginning to happen in Ontario in
11 a number of different ways. There are now, since the war, a
12 good many people engaged in the private practice of psychiatry,
13 just as in surgery, obstetrics, or any other specialty field.
14 Secondly, general hospitals now have accommodation, which they
15 did not have a few years ago, for taking care of psychiatric
16 patients. Thirdly, people are now admitted to mental hospitals
17 quite informally without legal requirements; once upon a time
18 the only way you could get into a State mental hospital,
19 Provincial mental hospital. Fourthly, the mental health
20 clinics that have been set up as Provincial organizations are
21 gradually being transferred under the administrative direction
22 of local general hospitals in communities and finally, and
23 most important from our point of view, medical care plans are
24 beginning, and some of them quite extensively, to cover the
25 treatment of psychiatric illness.



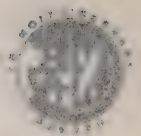
ways, as a result of accident of history, unlike other forms
of illness, this is a disease which is not hereditary, and
to the patient as people working in this field have become
increasingly aware of the fact that the disease is not
inherited, but is a disease of the mind, and that it is
and lay organizations have all been expressing the opinion,
backed up by some good evidence, mental illness should be
treated on the same basis as any other illness. As has been
said, this is an axiom from which we can proceed.
Now this is beginning to happen in Ontario in
a number of different ways. There are now, since the war, a
good many people engaged in the private practice of psychiatry,
just as in surgery, obstetrics, or any other specialty field.
Secondly, general hospitals now have accommodation, which they
did not have a few years ago, for taking care of psychiatric
patients. Thirdly, people are now admitted to mental hospitals
quite informally without legal requirements; once upon a time
the only way you could get into a State mental hospital,
Provincial mental hospital. Fourthly, the mental health
clinics that have been set up as Provincial organizations are
gradually being transferred under the administrative direction
of local general hospitals in communities and finally, and
most important from our point of view, medical care plans are
beginning, and some of them quite extensively, to cover the
treatment of psychiatric illness.



1 Now it is our concern sir that if, for the
2 first time in this Province, the coverage under a medical
3 insurance plan is laid down in the law, that this will, in
4 a sense, put up a barrier, or could put up a barrier to further
5 progress in this direction because, as it is now each company
6 is gradually sort of feeling their way forward. As accumulated
7 knowledge becomes available to them, one step further takes
8 place and we would be concerned if there was any indication
9 that we would be frozen at the status quo on the date any such
10 Bill became law, and that nothing further could be done except
11 to preserve the two systems that are now in effect.

12 It does not say so in Bill 163, but there are
13 some people who feel that exemptions, or I think this is under
14 Schedule A, implies that psychiatric care is not going to be
15 covered. Now it can be easily seen there how one can get
16 around this particular exemption.

17 One thing that we are concerned about is that
18 it be sort of open and above board. That this should be
19 covered and it should be known to be covered. You don't
20 have to read in the fine print of a law some way around it
21 in order to cover it. Our reasons for this particularly are
22 that we know that it is important in any medical treatment that
23 the physician-patient relationship be preserved as the
24 responsibility of a doctor for a patient, and that there is
25 a great deal implied in this and this is one of the reasons,



Now it is our concern that it, for the
first time in this Province, the coverage under a medical
insurance plan is laid down in the law, that this will, in
a sense, put up a barrier, or could put up a barrier to further
progress in this direction because, as it is now each company
is gradually sort of feeling their way forward. As accumulated
knowledge becomes available to them, one step further takes
place and we would be concerned if there was any indication
that we would be frozen at the status quo on the date any such
Bill became law, and that nothing further could be done except
to preserve the two systems that are now in effect.
It does not say so in Bill 103, but there are
some people who feel that exemptions, or I think this is under
Schedule A, implies that psychiatric care is not going to be
covered. Now it can be easily seen there how one can get
One thing that we are concerned about is that
it be sort of open and above board. That this should be
covered and it should be known to be covered. You don't
have to read in the fine print of a law some way around it
in order to cover it. Our reasons for this particularly are
that we know that it is important in any medical treatment that
the physician-patient relationship be preserved as the
responsibility of a doctor for a patient, and that there is
a great deal involved in this and this is one of the reasons.

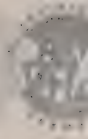


1 I think, the formula being proposed here is being proposed
2 the way it is.

3 We feel if this argument is a valid one for
4 medical care in general, certainly where the illness is one of
5 emotional origin, there again the relationship between doctor
6 and patient is very often the single most important thing in
7 the patient getting better.

8 If this is a good argument for medical care in
9 general, certainly a good argument in relation to psychiatric
10 care illness.

11 Finally, the way the insurance is now operating
12 and as one would reflect that it would operate under Bill 163
13 in anything like its present form, psychiatric care will be
14 available from the private practitioner in his office and in
15 the general hospital since there is nothing that excludes it
16 at the present time and most people who will be covered will
17 tend to choose this way. Now what concerned us is if it is
18 not extended, as we recommend to cover all psychiatric care
19 we think that this would mean psychiatrists, new psychiatrists
20 will tend to want to practice in this way because it is the
21 best way for their patients; the most satisfying way to
22 practice. This would, in the end, tend to denude and make
23 even more difficult the difficult circumstances that the
24 Provincial Government Service now has in staffing its hospitals,
25 so we would feel this can only be corrected by making it



1 I believe, that the medical care in general, certainly where the illness is one of
2 the kind which is a valid one for

3 We feel that this argument is a valid one for
4 medical care in general, certainly where the illness is one of
5 the kind which is a valid one for
6 the patient getting better.

7 It is a fact that the patient is getting better.
8 It is a fact that the patient is getting better.
9 It is a fact that the patient is getting better.
10 It is a fact that the patient is getting better.

11 Finally, the way the insurance is now operating
12 is that the way the insurance is now operating
13 is that the way the insurance is now operating
14 is that the way the insurance is now operating
15 is that the way the insurance is now operating
16 is that the way the insurance is now operating
17 is that the way the insurance is now operating
18 is that the way the insurance is now operating
19 is that the way the insurance is now operating
20 is that the way the insurance is now operating

21 In the past, new physicians
22 have been in this way because it is the
23 way that the insurance is now operating
24 is that the way the insurance is now operating
25 is that the way the insurance is now operating
26 is that the way the insurance is now operating
27 is that the way the insurance is now operating
28 is that the way the insurance is now operating
29 is that the way the insurance is now operating
30 is that the way the insurance is now operating



1 possible to practice medicine in Provincial institutions in
2 the same way that medicine is practiced in community hospitals
3 or general hospitals.

4 As far as our recommendations go sir, we have
5 presented our arguments I think elsewhere. We would be more
6 than happy to answer any questions relating to them. Recommen-
7 dations three, four, five and six I think are the ones that
8 bear most directly on the coverage and cost of coverage. One
9 of the things, in informal discussion that we have become
10 aware of is insurance companies and insuring agencies of various
11 kinds tend to back away from this whole field partly because
12 (a) we feel, erroneously, perhaps, the cost would be enormous,
13 astronomically out of the range of any conceivable amount which
14 can be paid. We could be wrong. Secondly, they do not have
15 much actuarial information to go on and we would like to suggest
16 the figures we have given here, which I have not heard disputed
17 by anybody, would provide a cushion for a number of years if
18 this was taken as probably the maximum that could conceivably
19 be spent on this care, the medical component of it and that at
20 the end of five or ten years, or five years one would then
21 have some experience on which one could establish a better
22 rating pattern, if necessary but we could not conceive how
23 this amount could be exceeded in the next few years.

24 The second point is that under the present plan
25 we are not suggesting this is going to cost \$13,000,000. more



possible to practice medicine in Provincial institutions in
the same way that medicine is practiced in community hospitals
on general hospitals.

As far as our recommendations go sir, we have
presented our arguments I think elsewhere. We would be more
than happy to answer any questions relating to them. Recommen-
dations three, four, five and six I think are the ones that
bear most directly on the coverage and cost of coverage. One
of the things, in informal discussion that we have become
aware of is insurance companies and financing agencies of various
kinds tend to back away from this whole thing partly because
(a) we feel, erroneously, perhaps, the cost would be enormous,
astronomically out of the range of any conceivable amount which
can be paid. We could be wrong. Secondly, they do not have
much actuarial information to go on and we would like to suggest
the figures we have given here, which I have not heard disputed
by anybody, would provide a cushion for a number of years if
this was taken as probably the maximum that could conceivably
be spent on this case, the medical component of it and that at
the end of five or ten years, or five years one would then
have some experience on which one could establish a better
rating pattern, if necessary but we could not conceive how
this amount could be exceeded in the next few years.

The second point is that under the present plan
we are not suggesting this is going to cost \$15,000,000 more



1 dollars than it does now to provide psychiatric care because
2 already at least half of this is chargeable against existing
3 insurance plan, or is being paid by the individuals themselves.
4 The other part is being paid by general tax tariffs anyway,
5 so that this does not mean an additional amount to this effect.

6 Our costs are not contained, since I gather that
7 the Commission may be interested in costs, they are not
8 contained in the preamble and recommendations, but on page 21
9 of the brief.

10 THE CHAIRMAN: Thank you. I think some of the
11 members of the Enquiry have some questions to ask you. Dr.
12 Butt?

13 DR. BUTT: I would be most interested to find out
14 if this organization is part of the O.M.A. Is it a section of
15 it or your own Association?

16 DR. CHALKE: It is not our own Association. It
17 is the Association of Psychiatrists and most of us are members
18 of O.M.A., in addition.

19 DR. BUTT: Do you have a section of psychiatry
20 within the Ontario Medical Association?

21 DR. CHALKE: Yes.

22 DR. BUTT: Does this brief essentially coincide
23 with their recommendations do you know?

24 DR. CHALKE: Well the O.M.A. has been informed
25 of this, the section has been informed. Whether the O.M.A.



dollars than it does now to provide psychiatric care because already at least half of this is chargeable against existing insurance plan, or is being paid by the individuals themselves. The other part is being paid by general tax tariffs anyway. so that this does not mean an additional amount to this effect. Our costs are not contained, since I gather that the Commission may be interested in costs, they are not contained in the preamble and recommendations, but on page 21 of the brief.

THE CHAIRMAN: Thank you. I think some of the members of the Inquiry have some questions to ask you. But?

DR. BUTT: I would be most interested to find out if this organization is part of the O.M.A. Is it a section of it or your own Association?

DR. CHAIRMAN: It is not our own Association. It is the Association of Psychiatrists and most of us are members of O.M.A., in addition.

DR. BUTT: Do you have a section of psychiatry within the Ontario Medical Association?

DR. BUTT: Does this brief essentially coincide with their recommendations you know?

DR. CHAIRMAN: Well the O.M.A. has been informed of this, the section has been informed. Whether the O.M.A.



1 is going to include or not include a section on neurology and
2 psychiatry, we cannot answer.

3 DR. BUTT: How many members would there be in
4 your Association?

5 DR. CHALKE: 275.

6 DR. BUTT: And of that membership would many of
7 them be practicing within what I know as the Ontario Hospital,
8 so-called mental hospital as such on a full-time salary?

9 DR. CHALKE: Yes. I would say approximately
10 half of them.

11 DR. BUTT: Half of them would be there?

12 DR. CHALKE: Yes.

13 DR. BUTT: Then we come to the next point of
14 your recommendation 4: Psychotherapy should be limited to
15 the cost of the equivalent of 50 hours per annum. Now in
16 the back you give \$12,500,000, or something, as the overall
17 cost. What are you suggesting this particular psychotherapy
18 would cost? Surely it isn't that whole \$12,000,000. I am
19 wondering what is represented by this recommendation 4.

20 DR. CHALKE: The total figure, if you refer to
21 page 21 sir, consultation is based on the ordinary medical
22 sense, a psychiatrist being asked to see a patient through
23 his referring doctor in the hospital or out of hospital. We
24 have estimated the number per thousand per annum in Ontario
25 would cost roughly \$1,000,000. Now having seen patients, some



psychiatry, we cannot answer.

DR. BUTT: How many members would there be in

Your Association?

DR. BUTT: And of that membership would many of

so-called mental hospital as such on a full-time salary?

DR. CHAIKIN: Yes. I would say approximately

half of them.

DR. BUTT: Half of them would be there?

DR. CHAIKIN: Yes.

DR. BUTT: Then we come to the next point of

Your recommendation: Psychotherapy should be limited to

the cost of the equivalent of 50 hours per annum. Now in

the back you give \$12,500,000, or something, as the overall

cost. What are you suggesting this particular psychotherapy

would cost? Surely it isn't that whole \$12,000,000. I am

wondering what is represented by this recommendation.

DR. CHAIKIN: The total figure, if you refer to

page 21 sir, consultation is based on the ordinary medical

sense, a psychiatrist being asked to see a patient through

his referring doctor in the hospital or out of hospital. We



1 of them you admit to the hospital. Some of them you treat
2 in your office by psychotherapy or by drugs or by a combination
3 of both and the \$5,000,000, which is ambulatory treatment
4 includes all the psychotherapy that would be given outside a
5 hospital.

6 DR. BUTT: This equivalent of 50 hours per
7 annum means outside of hospital?

8 DR. CHALKE: That means outside of hospital,
9 yes.

10 DR. BUTT: And therefore be \$6,000,000 more
11 or less. Is that right?

12 DR. CHALKE: Be \$5,000,000.

13 DR. BUTT: What about consultation?

14 DR. CHALKE: That is recommendation 3. We
15 separate treatment from consultation.

16 DR. BUTT: Treatment and consultation are
17 separated?

18 DR. CHALKE: Yes.

19 DR. BUTT: Then could you give me any idea of
20 -- you say half your organization are under salary at this
21 time. Now suppose they decide, as you seem to think they will,
22 they prefer to be under this type of thing. What amount of
23 money are they being paid and how much then would have to be
24 put into the premiums to cover these people?

25 In other words, half your organization would now



1 If there was a...
2 in your office...
3 of both...
4 includes all...
5 hospital.
6 DR. BUTT: This equivalent of 50 hours per
7 annum means outside of hospital?
8 DR. CHAIKIN: That means outside of hospital.
9 Yes.
10 DR. BUTT: And therefore is \$6,000,000 more
11 or less. Is that right?
12 DR. CHAIKIN: Be \$5,000,000.
13 DR. BUTT: ...
14 DR. CHAIKIN: That is recommendation 3. We
15 separate treatment from consultation.
16 DR. BUTT: Treatment and consultation are
17 separated.
18 DR. CHAIKIN: Yes.
19 DR. BUTT: Then could you give me any idea of
20 -- you say half your organization are under salary at this
21 time. You say they are...
22 they prefer to be under this type of thing. What amount of
23 money are they being paid and how much then would have to be
24 put into the premiums to cover these people?
25 In other words, half your organization would now



1 come under this type of bill rather than under the tax
2 situation of the Ontario Government.

3 DR. CHALKE: Right at the present time there is
4 a shortage which, if you want accurate figures, with your
5 permission Mr. Chairman, Dr. Henderson might give us.

6 If all the present beds for clinical work in the
7 Ontario Hospital Services were filled--this is not the
8 Superintendent. This is not the junior house staff, the bill
9 would be something like \$3,000,000 for salaries. Now they
10 are not filled. This is one of the problems, but if they were
11 all filled, it would cost the taxpayer from general revenue
12 something like \$3,000,000 to provide the service in Ontario
13 hospitals.

14 DR. BUTT: You feel, as time went on there
15 should at least be \$3,000,000 added?

16 DR. CHALKE: No. We have taken this into account
17 in estimating our cost for hospital. We filled up all the
18 vacancies because the point being we might attract people coming
19 to work in Ontario hospitals on a fee for service basis.

20 DR. BUTT: This is not the situation. In other
21 words, if the tax is now paying half this, or whatever it is
22 they are paying, from the Division of Health to the Mental
23 Hospitals, then these people are attracted because of this
24 Bill to private practice. Somebody has to pay for it.

25 DR. CHALKE: Yes, but on page 21, acute hospital



come under this type of bill rather than under the tax situation of the Ontario Government.

DR. CHAIKIN: Right at the present time there is a shortage which, if you want accurate figures, with your permission Mr. Chairman, Dr. Henderson might give us. It all the present beds for clinical work in the Ontario Hospital Services were filled--this is not the Superintendent. This is not the junior house staff--the bill would be something like \$3,000,000 for salaries. Now they are not filled. This is one of the problems, but if they were all filled, it would cost the taxpayer from general revenue something like \$3,000,000 to provide the service in Ontario hospitals.

DR. BUTT: You feel, as time went on there

should at least be \$3,000,000 added?

DR. CHAIKIN: No. We have taken this into account

in estimating the cost of the hospital. It is not all the vacancies because the point being we might attract people coming to work in Ontario hospitals on a fee for service basis.

DR. BUTT: This is not the situation. In other

words, if the tax is now paying half this, or whatever it is they are paying, from the Division of Health to the Mental Hospitals, then these people are attracted because of this Bill to private practice. Somebody has to pay for it.

DR. CHAIKIN: Yes, but we pay it, we are not



1 treatment includes roughly \$1,500,000 which is for Ontario
2 patients treated for acute illness in Ontario Hospitals.

3 DR. BUTT: This is acute hospital treatment,
4 four and a half million is what---

5 DR. CHALKE: This is acute treatment in both
6 general hospitals and in psychiatric hospitals and in Ontario
7 Provincial Mental Hospitals.

8 DR. BUTT: What percent would be normally in
9 Ontario Hospitals paid for by the tax dollar? Be a million
10 and a half?

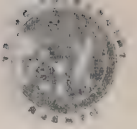
11 DR. CHALKE: A million and a half, yes. Two
12 million is chronic hospital care, which is almost
13 entirely in Ontario Hospitals. Those figures are inclusive
14 sir in all present treatment costs.

15 DR. BUTT: I notice by recommendation 7 that in
16 general the policy of co-insurance for all medical care is
17 recommended. I have two questions. Do you feel that co-
18 insurance and deductibles are a good thing as far as psychiatry
19 is concerned? In other words, the feeling being they are
20 personally responsible to some degree.

21 DR. CHALKE: In making this recommendation, we
22 are not restricting it to psychiatry.

23 DR. BUTT: I realize that.

24 DR. CHALKE: In general, yes. We feel some token
25 of personal involvement probably helps the patient to view this



1 treatment included roughly \$1,500,000 which is the amount
2 patients treated for acute illness in Ontario hospitals.

3 DR. BUTT: This is acute hospital treatment.

4 four and a half million is what---

5 DR. CHALKER: This is acute treatment in both

6 general hospitals and in psychiatric hospitals and in Ontario

7 provincial mental hospitals.

8 DR. BUTT: What percent would be normally in

9 Ontario Hospitals paid for by the tax dollar? Be a million

10 and a half?

11 DR. CHALKER: A million and a half, yes. Two

12 million is chronic hospital care, which is almost

13 entirely in Ontario Hospitals. These figures are inclusive

14 of all present treatment costs.

15 DR. BUTT: I notice by recommendation 7 that in

16 general the policy of co-insurance for all medical care is

17 recommended. I have two questions. Is that first co-

18 insurance and deductibles are a good thing as far as psychiatric

19 is concerned? In other words, the feeling being they are

20 personally responsible to some degree.

21 DR. CHALKER: In making this recommendation, we

22 are not restricting it to psychiatry.

23 DR. BUTT: I realize that.

24 DR. CHALKER: In general, yes, we feel some form

25 of personal involvement properly helps the patient to view this



1 thing realistically.

2 DR. BUTT: The next question is for information.

3 If a student or resident is taking psychoanalysis, I don't
4 know how this reflects with your group, whether this is part
5 of it or not, is it true or is it not true that they do pay
6 some of their own psychoanalysis?

7 DR. CHALKE: If a resident---?

8 DR. BUTT: Somebody who was prepared to do
9 psychoanalysis in the future.

10 DR. CHALKE: Will pay the entire cost themselves.

11 DR. BUTT: Could you tell me why?

12 DR. CHALKE: Well in the first place a psycho-
13 analyst's practice, if he is doing this formally and only
14 this, he sees his patient one hour a day for up to five times
15 a week for two years. Now the psychoanalysts that I know
16 of in this locality, many of them, their practice is heavily
17 loaded with physicians and physicians salaries pay them. In
18 fact, even this professional courtesy has never been required
19 in the traditional sense with a psychoanalyst because he
20 only has eight patients and his involvement with any one patient
21 may be anywhere up to \$3,000.00 or \$4,000.00 a year.

22 DR. BUTT: I think actually what I asked was that
23 if as a student he has to be psychoanalyzed, before he can
24 become a psychoanalyst---

25 DR. CHALKE: Does he inevitably---



RECEIVED
JAN 12 1944
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

DR. BUTT: The next question is for information.

of it or not, is it true or is it not true that they do pay some of their own psychoanalysts?

DR. BUTT: Somebody who was prepared to do

psychoanalysts in the future.

DR. CHALKER: Will pay the entire cost themselves.

DR. BUTT: Could you tell me why?

DR. CHALKER: Well in the first place a psycho-

analyst's practice, if he is doing them formally and only

this, he sees his patient one hour a day for up to five times

a week for two years. Now the psychoanalysts that I know

of in this locality, many of them, their practice is heavily

loaded with physicians and physicians salaries pay them. In

fact, even this professional courtesy has never been required

in the traditional sense with a psychoanalyst because he

only has eight patients and his involvement with any one patient

may be anywhere up to \$3,000.00 or \$4,000.00 a year.

DR. BUTT: I think actually what I asked was that

if as a student he has to be psychoanalyzed, before he can

become a psychoanalyst---

DR. CHALKER: Does he inevitably---



1 DR. BUTT: Does he have to pay?

2 DR. CHALKE: He has to pay if he does do it,
3 yes. Now he does not have to do it. It is not required.

4 DR. BUTT: But it is not required.

5 DR. CHALKE: It is not required that he had to
6 be a psychoanalyst. He can be an ordinary psychiatrist.

7 DR. BUTT: I appreciate that.

8 DR. CHALKE: There are eight panelists in
9 Toronto and that is all in the whole of Ontario. They have
10 had to be analyzed and paid their own.

11 DR. BUTT: Do you envisage this sort of coverage
12 should be covered by Bill 163?

13 DR. CHALKE: Their own analysis?

14 DR. BUTT: No, the payment of this.

15 DR. CHALKE: The payment of training an analyst?

16 DR. BUTT: The payment for psychoanalysis.

17 DR. CHALKE: No, it would not. This is why we
18 have put in recommendation 4 this whole business of restricting
19 psychotherapy to 50 sessions per annum. You can't do psycho-
20 analysis in 50 sessions per annum and this is because psycho-
21 analysis has within it a certain elective component and obvious-
22 ly insured for it, so that the number of 50 was really based
23 on a way to exclude psychoanalysis from coverage and at the
24 same time to take care, as near as we could visualize the
25 illness -- that most people with an illness requiring psycho-

DR. BUTT: Does he have to pay?

DR. CHAIKIN: He has to pay if he does do it.

Now he does not have to do it. It is not required.

DR. BUTT: But it is not required.

DR. CHAIKIN: It is not required that he had to

DR. BUTT: I appreciate that.

DR. CHAIKIN: There are eight panelists in

Toronto and that is all in the whole of Ontario. They have

had to be analyzed and paid their own.

DR. BUTT: Do you envisage this sort of coverage

should be covered by Bill 16?

DR. BUTT: No, the payment of this.

DR. CHAIKIN: The payment of training an analyst?

DR. BUTT: The payment for psychoanalysts.

DR. CHAIKIN: No, it would not. This is why we

have put in recommendation 4 this whole business of restricting

psychotherapy to 50 sessions per annum. You can't do psycho-

analysis in 50 sessions per annum and this is because psycho-

analysis has within it a certain elective component and obvious-

ly insured for it, so that the number of 50 was really based

on a way to exclude psychoanalysts from coverage and at the

same time to take care, as near as we could visualize the

illness -- that most people with an illness requiring psycho-



1 analysis therapy should be able to be treated in this way.

2 DR. BUTT: Would you consider excluding psycho-
3 analysis as such?

4 DR. CHALKE: No. It would be a little too
5 difficult to define it. This is the problem but by putting
6 it this way what we are really saying is if somebody goes into
7 analysis, that roughly one-fifth to one-fourth would be paid
8 for by their insurance. You may say that the co-insurance
9 carrier hopes for that but it is so difficult to say that, as
10 under the health component very few people can be psychoanalyzed
11 without doing something for their health so that we don't want
12 anybody to go into analysis simply because it is an insurance
13 coverage.

14 It would be cumbersome to exempt patients
15 especially in psychotherapy who then become ill on a complete
16 clinical basis. When did the analysis start? It would be
17 terribly hard for insurance companies or anybody to police in
18 that form so we are excluding psychoanalysis.

19 DR. BUTT: Do you envision by this bill that
20 there will be more psychiatrists, shall I say who want to leave
21 the Ontario Hospitals as places to work?

22 DR. CHALKE: We haven't said -- I would think
23 more probably it will attract more psychiatrists to Ontario
24 to fill up the Ontario services.

25 DR. BUTT: If they remain on salary I mean, as



DR. BUTT: Would you consider excluding psycho-

analysts as such?

DR. CHAMBER: No. It would be a little too

difficult to define it. This is the problem but by putting

it this way what we are really saying is if somebody goes into

analysis, that roughly one-fifth to one-fourth would be paid

for by their insurance. You may say that the co-insurance

carrier hopes for that but it is so difficult to say that as

under the health component very few people can be psychoanalyzed

without doing something for their health so that we don't want

anybody to go into analysis simply because it is an insurance

It would be cumbersome to exempt patients

specialized in psychotherapy who then become ill on a complete

clinical basis. When did the analysis start? It would be

terribly hard for insurance companies or anybody to police in

that form so we are excluding psychoanalysts.

DR. BUTT: Do you envision by this bill that

there will be more psychiatrists than I say who want to leave

the Ontario Hospitals as places to work?

DR. CHAMBER: We haven't said -- I would think

more probably it will attract more psychiatrists to Ontario

to fill up the Ontario services.



1 the situation is.

2 DR. CHALKE: Some of the younger ones would. I
3 can refer, with the Chairman's permission, to Dr. Moorhouse on
4 this question who is in a better position to answer it, being
5 in the Ontario Hospital, than I.

6 DR. MOORHOUSE: I think Dr. Butt that I would
7 foresee a great improvement in the care and treatment of the
8 mentally ill in the Provincial Hospitals because at the moment
9 I am sure that all members of the Enquiry are aware of the
10 dreadful dichotomy which exists between treatment of the
11 mentally ill patient in Ontario Hospital and treatment of the
12 mentally ill patient in the general hospital or in private
13 offices.

14 This is a most unfortunate thing that this
15 dichotomy has arisen but what happens to a patient on account
16 of it is that he loses track entirely of his private physician
17 when he comes into an Ontario Hospital and he loses track
18 entirely of his treating physician when he leaves an Ontario
19 Hospital and it is like east and west; never the twain do meet
20 and if medical care insurance includes psychiatrists in mental
21 hospitals clearly enough, he will leave the service, become a
22 private practitioner and act towards the Ontario Hospital as
23 an attending physician. In those circumstances you can see
24 clearly that the patient is going to be referred by his
25 practitioner to a psychiatrist attached to an Ontario Hospital



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

MR. MOORHOUSE: I think Dr. Butts that I would
foresee a great improvement in the care and treatment of the
mentally ill in the Provincial Hospital because at the moment
I am sure that all members of the Inquiry are aware of the
dreadful dichotomy which exists between treatment of the
mentally ill patient in Ontario Hospital and treatment of the
mentally ill patient in the general hospital or in private
hospitals.

This is a most unfortunate thing that this
dichotomy has arisen but what happens to a patient on account
of it is that he loses track entirely of his private physician
when he comes into an Ontario Hospital and he loses track
entirely of his treating physician when he leaves an Ontario
Hospital and it is like east and west; never the two do meet
and if medical care insurance includes psychiatrists in mental
hospitals clearly enough, he will leave the service, become a
private practitioner and set towards the Ontario Hospital as
an attending physician. In those circumstances you can see
clearly that the patient is going to be referred by his
private physician to the Ontario Hospital.



1 and this liaison would not be lost either going into hospital
2 or coming back out and I think this is one of the main items
3 of benefit to our mentally ill patients in this Province.

4 DR. BUTT: Is this situation not developing at
5 the present time by virtue of the attached psychiatric units
6 to general hospitals, close to the community rather than the
7 5,000 bed Ontario Hospitals?

8 DR. MOORHOUSE: This is developing, but
9 unfortunately still a vast majority of the acute illnesses are
10 treated in mental hospitals and this is a hard thing that you
11 cannot get around. They are all full of patients.

12 DR. BUTT: Are there a percentage of psychiatrists
13 now on part time salary and getting a fee for service?

14 DR. MOORHOUSE: Yes, there are some.

15 DR. BUTT: Is this increasing in numbers?

16 DR. MOORHOUSE: Slowly.

17 DR. BUTT: Would this be a satisfactory arrangement?
18 In other words, I cannot see how the Ontario Hospital -- how
19 this transition can take place that you recommend unless it
20 starts in this manner.

21 DR. CHALKE: It might well start in this manner.
22 At the same time there are now also, as I mentioned, informal
23 units in Ontario Hospitals where patients come and go just as
24 they do in general hospitals, psychiatric units. These can be
25 staffed with people from outside or from inside.



on coming back out and I think this is one of the main items
of benefit to our mentally ill patients in this Province.

DR. BUTT: Is this situation not developing at
the present time by virtue of the attached psychiatric units
in general hospitals?

2,500 bed Ontario Hospitals?

DR. MOORHOUSE: This is developing, but

unfortunately still a vast majority of the acute illnesses are
treated in mental hospitals and this is a hard thing that you
cannot get around. They are all full of patients.

DR. BUTT: Are there a percentage of psychiatrists

now on part time salary and getting a fee for services?

DR. MOORHOUSE: Yes, there are some.

DR. BUTT: Is this increasing in numbers?

DR. MOORHOUSE: Slowly.

DR. BUTT: Would this be a satisfactory arrangement?

In other words, I cannot see how the Ontario Hospital -- how
this transition can take place that you recommend unless it
starts in this manner.

At the same time there are now also, as I mentioned, informal

they do in general hospitals, psychiatric units. These can be
staffed with people from outside or from inside.



1 DR. BUTT: Are they at the present being staffed
2 by people outside?

3 DR. CHALKE: Yes.

4 DR. BUTT: Who are they paid by?

5 DR. CHALKE: By insurance. Some of them are
6 paid by the patient and the patient, in some cases, recovers
7 from well known medical insurance agencies.

8 DR. BUTT: But then he does not reside in a bed
9 in that hospital?

10 DR. CHALKE: Yes.

11 DR. BUTT: He does reside in a bed in that
12 hospital?

13 DR. CHALKE: Yes.

14 DR. BUTT: So at the present time the Ontario
15 Hospital beds are being utilized and paid for in fees by
16 a psychiatrist, is this correct, which are paid by the
17 insurance?

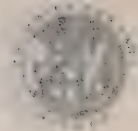
18 DR. CHALKE: These special units that have been
19 opened up. Now if you are committed to somewhere in the middle
20 of Dr. Miller's hospital on Queen Street and not to these special
21 units, there will be no fee collected.

22 DR. BUTT: Is there a special unit there?

23 DR. CHALKE: No.

24 DR. BUTT: Where is there a special unit?

25 DR. CHALKE: Dr. Moorhouse has one in New Toronto.



DR. BUTT: Are they at the present being staffed

by people outside?

DR. CHAIKIN: Yes.

DR. BUTT: Who are they paid by?

DR. CHAIKIN: By insurance. Some of them are

paid by the patient and the patient, in some cases, recovers

from what was a very serious condition.

DR. BUTT: But then he does not reside in a bed

in that hospital?

DR. CHAIKIN: Yes.

DR. BUTT: He does reside in a bed in that

hospital?

DR. CHAIKIN: Yes.

DR. BUTT: So at the present time the Ontario

Hospital beds are being utilized and paid for in fees by

a psychiatrist, is this correct, which are paid by the

insurance?

DR. CHAIKIN: These special units that have been

opened up. Now if you are committed to somewhere in the middle

of the hospital on Queen Street and not to these special

units, there will be no fee collected.

DR. BUTT: Is there a special unit there?

DR. CHAIKIN: No.

DR. BUTT: Where is there a special unit?

DR. CHAIKIN: Dr. Moorhouse has one in New Toronto.



1 Brockville has one.

2 DR. MOORHOUSE: Our hospital, Dr. Butt, behaves
3 just exactly the same way as a general hospital under these
4 circumstances and provides no medical care; only the standard
5 hospital provisions.

6 The attending psychiatrist is entirely and
7 totally responsible for the care and treatment of his patient,
8 the same as he would be if he was attending the same patient
9 in the general hospital.

10 DR. BUTT: And what happens to the long term
11 patient? In other words, somebody that has to be there nine
12 months or more?

13 DR. MOORHOUSE: He may be shifted then to chronic
14 care, if necessary in these circumstances. We just haven't
15 got the space to attend to him and he becomes a patient of the
16 hospital.

17 DR. BUTT: Do you feel he should be covered, or
18 the chronic care should be covered in some way?

19 DR. MOORHOUSE: Exactly the same way as any
20 other chronic care.

21 DR. BUTT: Now you are limited to 50 hours per
22 annum. How do you make these two figures?

23 DR. CHALKE: 50 hours per annum has nothing to
24 do with chronic hospital care.

25 DR. BUTT: This can go on to any length of time



1 Brookville has one.

2 DR. MOORHOUSE: I am not sure, Dr. Butt, but I

3 am not sure if the same way as the general hospital

4 circumstances are provided in medical care, only the

5 hospital provisions.

6 The attending psychiatrist is entirely and

7 totally responsible for the care and treatment of the

8 patient as he would be in the general hospital.

9 in the general hospital.

10 DR. BUTT: And what happens to the long term

11 patients in other words, would they be in the

12 months or more?

13 DR. MOORHOUSE: He may be shifted then to chronic

14 care, it necessarily in some circumstances. We just

15 have the space to admit to chronic care, but not

16 hospital.

17 DR. BUTT: Do you feel he should be covered, or

18 the chronic care should be covered in some way?

19 DR. MOORHOUSE: Exactly the same way as any

20 other chronic care.

21 DR. BUTT: Now you are limited to 50 hours per

22 annum. How do you make these two figures?

23 DR. CHAIKIN: 50 hours per annum has nothing to

24 do with chronic hospital care.

25 DR. BUTT: This is the same to any type of care



1 or any amount at all?

2 DR. CHALKE: In the same sense as the O.M.A.
3 schedule limits one in the case of chronic care. Somebody with
4 a stroke in a chronic care hospital, now the attending physician
5 is entitled to visit him once a month, twice a month up to a
6 certain maximum. This would apply the same way, we visualize,
7 for psychiatric care; not that he would be visited every day for
8 ten years as an acute patient.

9 DR. BUTT: I think I will quit with one more
10 question. The teaching and the grade of responsibility, you
11 do not feel this should be paid to the individual who is giving
12 the service but rather a pooling and division of fees. This
13 is on page 3, recommendation number 8.

14 What I am trying to tie it up with is the last
15 part where you say: "Medical, surgical or obstetrical services
16 provided to a covered patient in a hospital or institution
17 when these services are rendered by a physician paid a salary
18 to provide such services." Now this is the exemption the way
19 you wish the exemption to read, rather than the way it is in
20 this recommendation 9.

21 DR. CHALKE: These recommendations are separate
22 from each other.

23 DR. BUTT: I realize they are separate. If you
24 are paying the resident, or a student, if he is paid at all,
25 a salary, then how do you tie the two of them up? In other



1 or any amount of staff

2 DR. CHAIKIN: In the same sense as the O.M.A.

3 scheduled limits and in the case of the O.M.A. which
4 a strong in a hospital and hospital, now the attending physician
5 is entitled to visit him once a month, which is a month, so to
6 certain extent. This would apply in the same way, we visualize
7 for psychiatric care, not that we would be visited every day for
8 ten years as an acute patient.

9 DR. BUTT: I think I will drift with one more

10 question. The teaching and the staff of the hospital, you
11 do not feel this should be paid to the individual who is giving
12 the service but rather a central and division of labor. This
13 is on page 2, recommendation number 8.

14 What I am trying to tie it up with is the last

15 you were you say "medical, surgical, psychiatric services
16 provided to a patient patient in a hospital or institution
17 when these services are rendered by a physician paid a salary
18 to provide such services, and this is the exception, the rule
19 you also the exception is paid, whereas now in way it is to
20 this recommendation 9.

21 DR. CHAIKIN: These recommendations are separate

22 from each other.

23 DR. BUTT: I realize they are separate. If you

24 are paying the resident, or a specialist, if he is paid at all.
25 a salary, then how do you tie the two of them up? In other



1 words, are they tied up?

2 DR. CHALKE: No, they are not. It is presumptuous
3 to say because what we are talking about there is really in
4 relation to the whole business of education. It is not. It
5 is the overall clinical responsible staff. It is the head of
6 the Department and the two Assistant Supervisors and two junior
7 staff people will form a team responsible for treating, like
8 the referral idea, all these people are available to the patient.

9 DR. BUTT: Who would send the bill to the
10 insurance company?

11 DR. CHALKE: It would be a group of practitioners.

12 DR. BUTT: Would you set up a Corporation?

13 DR. CHALKE: I am not sure whether you can have
14 a Corporation practicing medicine, but it would be a group
15 clinic, like any other group clinic.

16 DR. BUTT: I think that is all.

17 THE CHAIRMAN: Miss Carpenter.

18 MISS CARPENTER: I was interested, Dr. Chalke,
19 in this fact that people would have 50 hours of treatment and
20 then be presumably responsible for the cost of their care after
21 that. You partially explained this. You said most people
22 wouldn't need more than 50 hours care. It is the outside
23 figure.

24 DR. CHALKE: Very much the outside figure because
25 we have been trying to get, and it is rather difficult to get --



1 words, are they tied up?

2 DR. CHAIKIN: No, they are not. It is presumptuous

3 to say because what we are talking about there is really in

4 relation to the whole business of education. It is not. It

5 is the overall clinical responsible staff. It is the head of

6 the department and the staff and the person and the person

7 staff people will form a team responsible for treating, like

8 the referral ideas, all these people are available to the patient.

9 DR. BUTT: Who would send the bill to the

10 insurance company?

11 DR. CHAIKIN: It would be a group of practitioners.

12 DR. BUTT: Would you set up a Corporation?

13 DR. CHAIKIN: I am not sure whether you can have

14 a Corporation practicing medicine, but it would be a group

15 of people, like an association.

16 DR. BUTT: I think that is all.

17 THE CHAIRMAN: All right.

18 MISS CARPENTER: I was interested, Dr. Chaikin,

19 in this fact that people would have 50 hours of treatment and

20 then be presumably responsible for the cost of their care after

21 that. You partially explained this. You said most people

22 wouldn't need more than 50 hours care. It is the outside

23 DR. CHAIKIN: Very much the outside figure because

24 the way we are trying to get it is in a more difficult to get



1 psychotherapy is not that extensive and there are no widely
2 available figures. In British Columbia where there is coverage
3 under the medical care plan and they have followed their cases
4 up the average treatments are somewhere between seven and ten.
5 It is really quite exceptional for anybody to go 50 hours.
6 Once a week for a whole year is much the exception rather than
7 the rule, and the maximum for this is probably around eight to
8 ten.

9 MISS CARPENTER: My thought is related to the
10 other question you raised, the co-insurance medical provision.
11 What happens to the lower income group if you have the co-
12 insurance feature? Is it the same amount of money for high
13 and low income groups? Do you feel that this would deter
14 people from seeking medical care?

15 DR. CHALKE: I think this is probably a matter,
16 have to be a matter of Government policy because if public
17 funds had paid premiums for people it seems to me because they
18 are medically indigent it would be highly unlikely the doctor
19 would be entitled to charge somebody who was medically unable
20 to afford to pay for medical care. It is one of the problems
21 about co-insurance, what do you do with people who can't afford
22 co-insurance.

23 MISS CARPENTER: You are asking the profession to
24 absorb this as welfare work and not charge for first call or
25 whatever it would be if the person wasn't able to pay?



It is really quite exceptional for anybody to go 50 hours.
The point, and the reason for this is probably around eight, is
that it is really quite exceptional for anybody to go 50 hours.
It is really quite exceptional for anybody to go 50 hours.
The point, and the reason for this is probably around eight, is
that it is really quite exceptional for anybody to go 50 hours.

MISS CARPENTER: My thought is related to the
what happens to the lower income group if you have the co-
insurance feature? Is it the same amount of money for high
and low income groups? Do you feel that this would deter
people from seeking medical care?

DR. CHAIKIN: I think this is probably a matter
have to be a matter of Government policy because if public
are medically indigent it would be highly unlikely the doctor
would be entitled to charge somebody who was medically unable
to afford to pay for medical care. It is one of the problems
co-insurance, and so you do with people who can't afford
co-insurance.

MISS CARPENTER: You are asking the profession to
absorb this as welfare work and not charge for first aid or
whatever it would be if the person wasn't able to pay?



1 DR. CHALKE: That is really a O.M.A. sort of
2 question. All we were saying there was that is the best
3 practice. We could see value in this. How you apply the
4 mechanism of who absorbs the difference, we would have to pass.
5 We would accept whatever the O.M.A. laid down as ethical under
6 these circumstances.

7 MISS CARPENTER: I think it is a question of
8 availability. People should not be deterred from getting medical
9 care if they need it. You feel in psychiatric illness it would
10 be a good idea to have co-insurance so they would have to pay
11 out of their own pocket a portion of some of their care.

12 DR. CHALKE: We weren't restricting it to the
13 psychiatric illness. I think it is equally important for a
14 person to have the care if they are in a position they need it,
15 if they are indigent.

16 MISS CARPENTER: Medically indigent, these
17 people in the gray areas. I think it is hard to understand
18 why you feel this is a satisfactory recommendation. I think
19 this is what I was asking, why do you feel this is a recommenda-
20 tion that you would support.

21 DR. CHALKE: It isn't specific to psychiatry.
22 It is the doctor-patient relationship, if you like, in all
23 situations, and the feeling about people getting things for
24 nothing, that there should be some token that one is paying
25 for this. It helps the person be concerned about what they



DR. CHAIKE: That is really a O.M.A. sort of

question. All we were saying there was that is the best

question. We would say that is the best

mechanism of the situation, we would have to pass.

It would be a question of the O.M.A. and how an individual under

those circumstances.

MISS CARPENTER: I think it is a question of

availability. People should not be deterred from getting medical

care if they need it. You feel in psychiatric illness it would

be a good idea to have co-insurance so they would have to pay

one of their own pocket a portion of what of their care.

DR. CHAIKE: We weren't restricting it to the

psychiatric illness. I think it is equally important for a

person to have the care if they are in a position that need it.

if they are indigent.

MISS CARPENTER: Medically indigent, these

people in the Gray areas. I think it is hard to understand

and you feel that is a satisfactory recommendation. I think

that is what I am saying. And you feel that is a recommendation.

tion that you would support.

DR. CHAIKE: It isn't specific to psychiatry.

It is the doctor-patient relationship, if you like, in all

situations, and the feeling about people getting things for

nothing, that there should be some token that one is paying

for this. It helps the person be concerned about what they



1 are doing.

2 MISS CARPENTER: You would agree they are not
3 getting them for nothing if they prepaid them. In the pre-
4 payment plan they have already paid, and sometimes paid more
5 than they are getting back.

6 DR. CHALKE: Psychologically the prepayment plan
7 through a group -- they are not aware of it. They think their
8 medical care is free because it got deducted so far back at
9 source and they never saw it anyway. It is symbolic participa-
10 tion that brings it home to them. This is only an argument
11 for it. It isn't crucial to our overall thesis at all. It
12 is merely an observation we would like to bring the Commission's
13 attention to. It is a relative thing in the thesis.

14 MISS CARPENTER: The other question, in relation
15 to this chronic care, I was interested in the development that
16 took place in Toronto in the home care of psychiatric patients.
17 Do you think this is a trend to more people being taken care
18 of in their own homes, foster homes, boarding homes and so help
19 in the chronic care problems.

20 DR. CHALKE: We hope so. There it wouldn't be
21 chronic care, but they would be like anybody else living in a
22 welfare residence, if the doctor was needed he would be on call.

23 MISS CARPENTER: And therefore it would be less
24 costly. The last question was one dealing with the very top of
25 page 11:



MISS CARPENTER: You would agree they are not

getting them for nothing if they prepaid them. In the pre-

paid plan they have prepaid, and sometimes they have

than they are getting back.

DR. CHAPPEL: Psychologically the prepaid plan

is a very good one. It gives the patient a sense of responsibility.

medical care is free because it got deducted so far back at

the time they made the payment. It is a very good plan.

tion that brings it home to them. This is only an argument

for it. It isn't crucial to our overall thesis at all. It

is only a relative thing in the thesis.

attention to. It is a relative thing in the thesis.

MISS CARPENTER: The other question, in relation

to this chronic care, I was interested in the development that

took place in the development of the chronic care plan.

of in their own homes, foster homes, boarding homes and so help

in the chronic care problems.

DR. CHAPPEL: We hope so. There it wouldn't be

chronic care, but they would be like anybody else living in a

regular home, and they would be treated as such.

MISS CARPENTER: And therefore it would be less

costly. The last question was one dealing with the very top of



"Costs of diagnostic services by ancillary psychiatric personnel should be dealt with the same as commensurate personnel in any other specialty."

Are there any compensating personnel or to whom are you referring in your psychiatric personnel, ancillary personnel and psychiatric hospitals as against other kinds of illnesses?

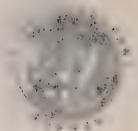
DR. CHALKE: Clinical psychologists who perform these diagnostic tests, and we were thinking that compensating personnel would be the ward officer like they have with the autolarginist. Our feeling is now this has been centered in hospitals and recoverable under the Ontario Hospital Commission. We don't know whether insurance is going to change this pattern but if they do we are really saying our technical ancillary personnel should be in as are the autolarginist's.

MISS CARPENTER: Would it pay for services, outpatient or doctor's fees. They would be lost if this kind of thing was included under Bill 163.

DR. CHALKE: No, they should be included probably under Hospital Insurance now, which they are now except it is not far enough into the -- go far enough into the outdoors. It is for the general hospital psychiatric units.

THE CHAIRMAN: Mr. Coulter?

MR. COULTER: Mr. Chairman, I have quite a few questions. Most of my questions have already been asked. I



"Costs of diagnostic services by ancillary psychiatric personnel should be dealt with the same as commensurate personnel in any other specialty."

Are there any compensating personnel or to whom

are you referring to the psychiatric hospitals?

Psychiatric hospitals are not the same as other kinds of

hospitals

DR. CHALKER: Clinical psychologists who perform

these diagnostic tests, and we were thinking that compensating

personnel would be the ward officer like they have with the

autolateralist. Our feeling is now this has been centered in

hospitals and recoverable under the Ontario Hospital Commission.

We don't know whether insurance is going to change this pattern

but if they do we are really saying our technical ancillary

personnel should be in as are the autolateralist's.

MISS CARPENTHER: Would it pay for services,

outpatient or doctor's fees. They would be lost if this kind

of thing was taken over by the

DR. CHALKER: No, they should be included probably

in the hospital insurance plan. When they are included in the

plan they are not lost. They are paid for by the hospital

is for the general hospital psychiatric units.

THE CHAIRMAN: Mr. Coulter?

MR. COULTER: Mr. Chairman, I have quite a few

questions. First of all, I would like to know how many



1 am a little concerned about the number of psychiatrists. There
2 are 275. The first speaker gave some figures which he gave too
3 fast for me to keep track of, I think it was the number of
4 visits that you had to attend to or the number of people that
5 asked to see psychiatrists in a year or had been admitted to
6 mental hospitals. Could I have those figures again?

7 DR. MILLER: Fifteen thousand admissions to
8 psychiatric institutions. That includes Ontario Hospitals,
9 General Hospitals, Psychiatric Units and Private Institutions
10 for psychiatric treatment. The other figure was 25,000 people
11 attending all kinds of community psychiatric units for people
12 with psychiatric problems of various kinds.

13 MR. COULTER: Is the 15,000 included in the
14 25,000?

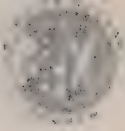
15 DR. CHALKE: No. This is outpatients.

16 MR. COULTER: 40,000 people all told.

17 DR. CHALKE: Some people go to clinics as out-
18 patients, treated for three months and may end up admitted.
19 There may be some overlap both ways.

20 MR. COULTER: To follow this up, then, may I
21 ask why there are not more of you people because there apparently
22 is lots of work.

23 DR. CHALKE: Well, sir, one reason is because
24 the practice of this branch of medicine has been singularly unattrac-
25 tive compared to the surgeons and radiologists and the others not



The first speaker gave some figures which he gave too
visits that you had to attend to or the number of people that
asked to see psychiatrists in a year or had been admitted to
mental hospitals. Could I have those figures again?

DR. MILLER: Fifteen thousand admissions to

General Hospital, Psychiatric Units and Private Institutions
for psychiatric treatment. The other figure was 25,000 people
with psychiatric problems of various kinds.

MR. COUTER: Is the 25,000 included in the

25,000?

DR. CHAIKE: No. This is outpatients.

MR. COUTER: 40,000 people all told.

DR. CHAIKE: Some people go to clinics as out-

patients, treated for three months and may end up admitted.

There may be some overlap both ways.

MR. COUTER: To follow this up, then, may I

ask why there are not more of you people because there apparently
is lots of work.

DR. CHAIKE: Well, sir, one reason is because



1 necessarily employed in practicing medicine in the traditional
2 sense that very few people have been encouraged into the field.

3 Secondly it is true advances in treatment have
4 taken place in the last ten or fifteen years, since the last
5 war and have had much to do in making it more attractive.
6 From the time a man starts medicine until he hangs his shingle
7 as a psychiatrist he has spent nearly twelve years, so we are
8 now only beginning to reap the rewards of the new look and the
9 attractiveness of psychiatry. In Canada now we are producing
10 less than 50 to 60 psychiatrists a year with all post-graduate
11 training.

12 MR. COULTER: To follow this up, I think the
13 statement was made, and I am not sure who made it, the
14 statement was made that if psychiatry were included in Bill
15 163 this would induce more people into the business. As a
16 layman I fail to see this. It takes twelve years to become
17 a qualified psychiatrist. I think it would be a matter of
18 money that would induce more people into it.

19 DR. CHALKE: Yes. I don't think it would induce
20 more people to enter psychiatry. I think it might well,
21 however, keep people in Ontario who now may go somewhere else
22 to practice, and might even bring people from elsewhere to
23 Ontario because if we achieve our particular goal at once we
24 would be the first Province in Canada to have done so, and it
25 would certainly discourage our own graduates, our own post-

2 sense that very few people have been encouraged into the field.
 3 Secondly it is true advances in treatment have
 4 taken place in the last ten or fifteen years, since the last
 5 war and have had much to do in making it more attractive.
 6 From the time a man starts medicine until he hangs his shingle
 7 as a psychiatrist he has spent nearly twelve years, so we are
 8 attractedness of psychiatry. In Canada now we are producing
 9 less than 50 to 60 psychiatrists a year with all post-graduate

12 MR. COUTER: To follow this up, I think the

13 statement was made, and I am not sure who made it, the
 14 statement was made that if psychiatry were included in Bill
 15 163 this would induce more people into the business. As a
 16 layman I fail to see this. It takes twelve years to become
 17 a qualified psychiatrist. I think it would be a matter of
 18 money that would induce more people into it.
 19 DR. CHAIKIN: Yes. I don't think it would induce

20 more people to enter psychiatry. I think it might well,
 21 however, keep people in Ontario who now may go somewhere else
 22 to practice, and might even bring people from elsewhere to
 23 Ontario because if we achieve our particular goal at once we
 24 would be the first Province in Canada to have done so, and it
 25 would certainly discourage our own graduates, our own post-



1 graduates when they are finished training going outside Ontario.
2 It would be quite an advance. I think it would help people
3 stay and bring back a good many Canadians trained in the
4 United States. To have this type of opportunity to practice
5 we might well bring some of these people back.

6 MR. COULTER: Would you care to give an opinion,
7 if you were included in Bill 163, would this increase the
8 load on the number of people we now have practicing or not.

9 DR. CHALKE: I don't think so because it is
10 already included in 163 to all intents and purposes except for
11 the Ontario Hospitals which are not explicitly included or
12 excluded. As I say we could practice just the way we want
13 to because the clause in 163, you can't pay for services that
14 have already been paid for. The Ontario Government would be
15 just and fair and take all the people on staff. It isn't
16 a question of getting around 163. I don't think there would
17 be any more work. I think it would be differently distributed.
18 Mind you we would still be short of psychiatrists but we are
19 short of them under the present circumstances.

20 MR. COULTER: Another question I had: Some place
21 in your brief there is mention of teaching hospitals. How
22 many are there in Ontario?

23 DR. CHALKE: This includes, of course, the
24 Departments of Psychiatry in general hospitals, Toronto General,
25 St. Michael's, Western here are all teaching general hospitals,



2 It would be quite an advance. I think it would help people
3 stay and bring back a good many Canadians trained in the
4 United States. To have this type of opportunity to practice
5 we might well bring some of these people back.

6 MR. COULTER: Would you care to give an opinion,
7 if you were included in Bill 103, would this increase the
8 load on the number of people we now have practicing or not.
9 DR. CHAMBER: I don't think so because it is

10 already included in 103 to all intents and purposes except for
11 the Ontario Hospitals which are not explicitly included or
12 excluded. As I say we could practice just the way we want
13 to because the clause in 103, you can't pay for services that
14 have already been paid for. The Ontario Government would be
15 just and fair and take all the people on staff. It isn't
16 a question of getting around 103. I don't think there would
17 be any more work. I think it would be differently distributed.
18 Mind you we would still be short of psychiatrists but we are
19 short of them under the present circumstances.

20 MR. COULTER: Another question I had: Some place
21 in your brief there is mention of teaching hospitals. How
22 many are there in Ontario?

23 DR. CHAMBER: This includes, of course, the
24 Department of Psychiatry in Queen's University, Kingston General
25 Hospital, and all the teaching hospitals in Ontario.



1 999 Queen Street is a teaching hospital affiliated with the
2 University of Toronto. In London the St. Joseph and Victoria
3 as general hospital units are teaching units and the Ontario
4 Hospital, London. There are six Ontario Hospitals which are
5 teaching hospitals affiliated with Universities by agreement
6 and about seven or eight general hospital psychiatric units.

7 MR. COULTER: One further question in your
8 opinion what is the chief reason why there are not more people
9 in, why you don't have more students?

10 DR. CHALKE: Well, one thing is that we are
11 short of doctors. Other people from the University would be
12 more qualified to say how many graduates we ought to have in
13 medicine. I think we are short at the present time. We need
14 more medical schools. Of these roughly 6% are going into
15 psychiatry a year starting up post-graduate training in
16 psychiatry, which isn't too bad. We could do with more, but
17 I think we would never get more unless there are, first of all,
18 more doctors being produced because there is a constant pull.
19 We want people to go into general practice. We don't want
20 everybody to be specialized, and psychiatry can't get all of
21 the specialists. I think circumstances have been unattractive
22 in the past and discouraged people. We know this is true
23 because a public opinion poll of medical students as to the
24 status position of psychiatry in the past has always been very
25 low. If my colleagues permit me, it wasn't in the past the



as general hospital units are teaching units and the Ontario Hospital, London. There are six Ontario Hospitals which are teaching hospitals affiliated with Universities by agreement and about seven or eight general hospital psychiatric units.

MR. COUTLER: One further question in your

opinion what is the chief reason why there are not more people in, why you don't have more students?

DR. CHAIKIN: Well, one thing is that we are

short of doctors. Other people from the University would be more qualified to say how many graduates we ought to have in medicine. I think we are short at the present time. We need

psychiatry, which isn't too bad. We could do with more, but I think we would never get more unless there are, first of all, more people who are interested in psychiatry. We don't have enough people who are interested in psychiatry. We don't have enough people who are interested in psychiatry.

the specialists. I think circumstances have been unattractive in the past and discouraged people. We know this is true because a public opinion poll of medical students as to the status position of psychiatry in the past has always been very low. If my colleagues permit me, it wasn't in the past the



1 brightest students of the medical schools went into psychiatry.

2 This has changed now.

3 MR. COULTER: That permitted me to ask another

4 question, probably I shouldn't. Thank you very much Mr.

5 Chairman. I was going to ask is this the old school or the new

6 school. Thank you very much Mr. Chairman.

7 THE CHAIRMAN: Mr. Mulrooney.

8 MR. MULROONEY: I am interested in recommendation

9 number two which recommends

10 "All medical care should commence with the family

11 practitioner who, when it becomes advisable, would

12 refer his patient to other physicians. It therefore

13 follows that the family practitioner is to be re-

14 imbursement for diagnosis and for treatment of psychia-

15 tric disorder including psychotherapy according to the

16 general tariff of the Ontario Medical Association."

17 Is this recommendation made because there are

18 too few psychiatrists, perhaps in certain areas of the Province?

19 I have been unaware of general practitioners, family doctors

20 rendering any psychiatric services. Probably there are some,

21 but I am not aware of it. I am a little surprised with the

22 recommendation that the family practitioner should be reimbursed

23 for diagnosis and treatment in the psychiatric field. Would

24 you explain that for us.

25 DR. CHALKE: In the first place the family



1 brightest students of the medical schools went into psychiatry.

2 This has changed now.

3 MR. COUTLER: That permitted me to ask another

4 question, probably I shouldn't. Thank you very much Mr.

5 Chairman. I was going to ask is this the old school or the new

6 MR. MURPHY: I am interested in recommendation

7 number two which recommends

8 "All medical care should commence with the family

9 practitioner who, when it becomes advisable, would

10 refer his patient to other physicians. It therefore

11 follows that the family practitioner is to be re-

12 imbursed for diagnosis and for treatment of psychia-

13 tric disorder including psychotherapy according to the

14 General tariff of the Ontario Medical Association."

15 Is this recommendation made because there are

16 too few psychiatrists, perhaps in certain areas of the Province?

17 I have been unaware of general practitioners, family doctors

18 rendering any psychiatric services. Probably there are some,

19 but I am not aware of it. I am a little surprised with the

20 recommendation that the family practitioner should be reimbursed

21 for diagnosis and treatment in the psychiatric field. Would

22 you explain that for us.

23 DR. CHALKER: In the first place the family



1 practitioner does a great deal of psychiatry. He doesn't do
2 it openly, call it psychiatry, partly because it is good
3 practice not to. He spends a good deal of time straightening
4 out family problems. Treatments are made on anywhere from
5 one-third or one-half of all the patients coming in in a day
6 because these people have emotional problems. Many backaches,
7 headaches, tummy aches and so on -- this is a complication of
8 physical health. This doesn't appear anywhere as psychiatric
9 work. Secondly now more and more patients who are treated in
10 psychiatric hospitals go back to their home communities, and
11 even though we talk about having psychiatric private practice,
12 this is pretty hard to get into smaller communities. Where the
13 patients go back, particularly today when many patients are
14 kept well, or nearly well upon certain medication we
15 want the family doctor to continue these medications, to
16 oversee them, unless it is so highly specialized it can't be
17 done. Under some of the existing insurance plans if he put
18 in saw a patient once a month for continuing care of chronic schizo-
19 phrenia which he is quite capable of doing, the insurance
20 company wouldn't pay him. They say they won't pay for treatment
21 of any psychiatric disorder once diagnosis has been made.

22 Two points: One is continuing care and secondly
23 to face reality, if you like. The Ontario Medical Association
24 lays down a tariff for psychotherapy done by general practitioners.
25 It isn't anything to do with insurance or anything else. Many

practice not to. He spends a good deal of time straightening out family problems. Treatments are made on anywhere from one-third or one-half of all the patients coming in a day because these people have emotional problems. Many headaches, headaches, tummy aches and so on -- this is a complication of physical health. This doesn't appear anywhere as psychiatric work. Secondly now more and more patients who are treated in psychiatric hospitals go back to their home communities, and even though we talk about having psychiatric private practice, this is pretty hard to get into smaller communities. Where the patients go back, particularly today when many patients are kept well, or nearly well upon certain medication we want the family doctor to continue these medications, to oversee them, unless it is so highly specialized it can't be done. Under some of the existing insurance plans it is put in saw a patient once a month for continuing care of chronic ailments. phrenia which he is quite capable of doing, the insurance company wouldn't pay him. They say they won't pay for treatment of any psychiatric disorder once diagnosis has been made.

Two points: One is continuing care and secondly to face reality, if you like. The Ontario Medical Association



1 family doctors sit down for half an hour with husband and wife
2 to discuss problems that they both come with. In the past he
3 could only charge the usual office visit whereas, in fact, he
4 is spending a great deal of time and using technical knowledge.
5 In the third place as Dr. Miller said in the introduction we
6 are now teaching our medical students to do such therapy and
7 to carry out this form of care. This is one of the things
8 that every general practitioner should know. It is true this
9 hasn't had an impact on the practice of medicine in this
10 Province yet because it takes a few years for most doctors to
11 be practicing.

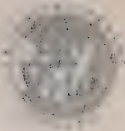
12 MR. MAHONEY: Is there liaison between the family
13 doctor and the psychiatrist where there is referral.

14 DR. CHALKE: There is, as Dr. Moorhouse mentioned
15 more when the psychiatrist is also a member of the community.
16 Where it becomes very cumbersome is where a family doctor sends
17 someone to the Ontario Hospital and the patient comes back.
18 There isn't the same contact there. There should be the same
19 contact between the psychiatrist and the family doctor as there
20 is between the internist the family doctor refers her problems
21 to or the gynecologist who he refers her gynecological problems to.

22 MR. MAHONEY: Thank you, sir.

23 THE CHAIRMAN: Mr. Whitney?

24 MR. WHITNEY: Mr. Chairman, one question: How
25 many patients would you estimate, and this is probably a guess,



to discuss problems that they both come with. In the past he could only charge the usual office visit whereas, in fact, he is spending a great deal of time and using technical knowledge. In the third place as Dr. Miller said in the introduction we are now teaching our medical students to do such therapy and to carry out this form of care. This is one of the things that every general practitioner should know. It is true this hasn't had an impact on the practice of medicine in this Province yet because it takes a few years for most doctors to be practicing.

MR. MAHONEY: Is there liaison between the family doctor and the psychiatrist where there is referral. More when the psychiatrist is also a member of the community. Where it becomes very cumbersome as where a family doctor sends someone to the Ontario Hospital and the patient comes back. There isn't the same contact there. There should be the same contact between the psychiatrist and the family doctor as there is between the internist the family doctor refers her problems to or the gynecologist who he refers her gynecological problems

MR. MAHONEY: Thank you, sir.

MR. WHITNEY: Mr. Chairman, one question: How many patients would you estimate, and this is probably a guess,



1 but you may have figures, how many would you estimate are
2 referred to the practicing psychiatrist and how many come
3 directly.

4 DR. CHALKE: That is a very difficult question
5 to answer, sir, partly because some clinics and some psychiat-
6 rists won't take anybody unless they are referred. That is a
7 man may call up the clinic and say I need to see you and the
8 doctor says, I am sorry I only see patients when they come
9 through family doctors, which chases the patient around the
10 other way. I really couldn't answer that question. I don't
11 know if there is an answer. Some clinics do take people
12 without necessarily requiring referral. I don't know whether
13 Dr. Henderson would like to hazard a guess.

14 DR. HENDERSON: The way we operate the Public
15 Clinic there is a referral practice, but in overall, approxi-
16 mately 75% are referred by medical sources, family doctors or
17 hospital's outpatient departments or services of this kind.
18 Some of the clinics do provide services to the individual on
19 their own request, and this may range as high as 20 to 30%
20 referral of patients that are treated in the clinic. This is
21 high. On the average less than 10%, likely 5%. In most
22 instances even when the patient does present himself for
23 assistance of this kind contact is made with the family
24 physician in order to relate services to the general medical
25 care of the individual.



RECEIVED
JAN 10 1934
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

150

1 but you may have figures, how many would you estimate are
2 referred to the practicing psychiatrist and how many come
3 directly.

4 DR. CHAIKIN: That is a very difficult question

5 to answer, I really couldn't answer that question. I don't
6 think anybody would take anybody unless they are referred. That is a
7 man may call up the clinic and say I need to see you and the
8 doctor says, I am sorry I only see patients when they come
9 through family doctors, which causes the patient around the
10 other way. I really couldn't answer that question. I don't
11 know if there is an answer. Some clinics do take people
12 without necessarily requiring referral. I don't know whether
13 Dr. Henderson would like to hazard a guess.

14 DR. HENDERSON: The way we operate the Public

15 Clinic there is a referral practice, but in overall, approxi-
16 mately 75% of the patients are referred, and 25% are
17 hospital's outpatient departments or services of this kind.
18 Some of the clinics do provide services to the individual on
19 their own request, and this may range as high as 20 to 30%
20 referral of patients that are treated in the clinic. This is
21 high. On the average less than 10%, likely 5%. In most
22 instances even when the patient does present himself for
23 assistance of this kind contact is made with the family

24
25



1 MR. WHITNEY: You mentioned clinics, do
2 psychiatrists also practice in connection with clinics or
3 government clinics.

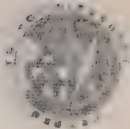
4 DR. CHALKE: No. The reason I asked Dr. Henderson
5 is we do have organized clinics that do keep organized statis-
6 tics as to where their patients are referred from and these
7 are compiled in the Parliament Buildings. That is why I
8 thought Dr. Henderson might have this. Psychiatrists work
9 in individual practice like any other specialist or they may
10 work in a group of other specialties in a group, two surgeons,
11 an internist, a paediatrician and a psychiatrist or they work
12 in groups, particularly where these groups have been sponsored
13 originally by Government services or in hospitals they practice
14 as a group.

15 MR. WHITNEY: I might say, Mr. Chairman, Mr. Coulter says
16 I simply asked these questions to let other members of the
17 Commission know I haven't been to see them yet.

18 THE CHAIRMAN: Mrs. Aylen.

19 MRS. AYLEN: On page 17, recommendation number
20 6, you state that chronic hospital psychiatric care should be
21 on the same basis as all other care. Is care only the treatment
22 that the patients receive from the psychiatrist or does it
23 embrace any other factor.

24 DR. CHALKE: We were obviously uncertain in
25 this particular recommendation, in discussing it, because we



MR. WHITNEY: You mentioned clinics, do

Government clinics.

Dr. CHAIKIN: No. The reason I asked Dr. Henderson

is we to have organized clinics, as I have mentioned before,

as to where their patients are referred from and these

are compiled in the Parliament Buildings. That is why I

thought Dr. Henderson might have this. Psychiatrists work

in individual practice like any other specialist or they may

work in a group of other specialists in a group, two surgeons,

an internist, a paediatrician and a psychiatrist or they work

in groups, particularly where these groups have been sponsored

by the Government. I might say, Mr. Chairman, Mr. Coulter says

as a group. I simply asked these questions to let other members of the

Commission know I haven't been to see them yet.

THE CHAIRMAN: Mrs. Ayles.

MRS. AYLES: On page 17, recommendation number

6, you state that chronic hospital psychiatric care should be

on the same basis as all other care. Is care only the treatment

that the patients receive from the psychiatrist or does it

embrace any other factor.

DR. CHAIKIN: We were obviously uncertain in



1 weren't clear as to chronic care for anybody with psychosis
2 or arthritis and so on, any chronic hospital, how does it
3 get in the medical insurance plan. It is a very difficult
4 thing to visualize how you do this. We don't want to discourage it.
5 It seemed to us that one of the problems, for example, in the
6 chronic hospital is that you have to have physicians on staff
7 like the general hospital, you have to have physiotherapy and
8 nursing services sort of from day to day to provide proper
9 rehabilitation plans. Each patient may still want to see his
10 old doctor who has looked after him for a long time back. We
11 weren't sure how these two should fit together, whether hospital
12 services should pay for medical practitioners and individual
13 services for individual patients to be covered by medical
14 insurance plans or not. What we were really saying is we feel
15 what does apply to people who are ill in a physical sense
16 applies in the same way to chronically ill with mental disorders.

17 MRS. AYLEN: Are you suggesting medical care
18 for mental patients should be paid for by the Ontario Hospital
19 Services Commission.

20 DR. CHALKE: As far as hospital.

21 MRS. AYLEN: I mean their care in hospital.

22 DR. CHALKE: Very definitely. We would think
23 that would be the greatest advance, and we would hope the next
24 step, and we didn't put it in our brief because we didn't think
25 it was appropriate to the subject of this Enquiry. We have



1 weren't clear as to chronic care for anybody with psychosis
2
3 get in the medical insurance plan. It is a very difficult
4 thing to visualize how you do this. We don't want to discourage it.
5 It seemed to us that one of the problems, for example, in the
6 chronic hospital is that you have to have physicians on staff
7 like the general hospital, you have to have physiotherapy and
8 nursing services sort of from day to day to provide proper
9 rehabilitation plans. Each patient may still want to see his
10 old doctor who has looked after him for a long time back. We
11 weren't sure how these two should fit together, whether hospital
12 services should pay for medical practitioners and individual
13
14
15 what does apply to people who are ill in a physical sense
16 applies in the same way to chronically ill with mental disorders
17 MRS. ALLEN: Are you suggesting medical care
18 for mental patients should be paid for by the Ontario Hospital
19
20 DR. CHALKER: As far as hospital.
21 MRS. ALLEN: I mean their care in hospital.
22 DR. CHALKER: Very definitely. We would think
23 that would be the greatest advance, and we would hope the next
24 step, and we didn't put it in our brief because we didn't think
25 it was appropriate to the subject of this Inquiry. We have



1 urged it elsewhere and in other representations that they do
2 this.

3 MRS. AYLEN: Maybe my question was inappropriate
4 then. I am sorry.

5 THE CHAIRMAN: Dr. Galloway.

6 DR. GALLOWAY: Just some clarification, Mr.
7 Chairman. It seems to me from your brief and other information
8 that the whole field of psychiatry is changing, not only is the
9 method of treatment changing but the type of patient is changing.
10 In this changing practice in your private practice, what
11 percentage of people would you be seeing say who are actually
12 psychotic as being opposed to those who have some minor
13 personality changes, and those who would be seen in general
14 hospitals and general office practice.

15 DR. CHALKE: This varies, of course, with the
16 particular hospital. The general hospitals and the Ontario
17 Hospitals open units pretty well see the same pattern. It runs
18 roughly around 40% are psychotic. The patient is hospitalized.
19 This isn't a doctor sitting in the Medical Arts doing consul-
20 tations for his colleagues. He wouldn't see 40%, but patients
21 in general hospitals and psychiatric hospitals and Ontario
22 Hospitals, 40% psychotic. I would think that 30% suffer from
23 crippling neurosis. This means they are too sick to be
24 outside. They are crippled to the point where they have to
25 be in the hospital. The others are there for various things



1. I am sorry. I am sorry.

2. This

3. I am sorry. I am sorry.

4. I am sorry. I am sorry.

5. THE CHAIRMAN: Dr. Galloway.

6. DR. GALLOWAY: Just some clarification, Mr.

7. Chairman. It seems to me from your brief and other information

8. that the whole field of psychiatry is changing, not only is the

9. method of treatment changing, but the whole field is changing.

10. In this changing practice in your private practice, what

11. percentage of people would you be seeing say who are actually

12. psychotic as being opposed to those who have some minor

13. personality changes, and those who would be seen in general

14. hospitals and general office practice.

15. DR. CHALKER: This varies, of course, with the

16. particular hospital. The general hospitals and the Ontario

17. Hospitals open units pretty well see the same pattern. It runs

18. roughly around 40% are psychotic. The patient is hospitalized.

19. This isn't a doctor sitting in the Medical Arts doing consul-

20. tations for his colleagues. He wouldn't see 40%, but patients

21. in general hospitals and psychiatric hospitals and Ontario

22. Hospitals, 40% psychotic. I would think that 30% suffer from

23. crippling neurosis. This means they are too sick to be

24. outside. They are crippled to the point where they have to

25. be in the hospital. The others are there for various things



1 including organic brain diseases. If you are in office
2 practice you are going to see possibly more psychosomatic
3 problems, migraine headaches, tension. You see people who
4 have a tendency to take barbituates who want to get off the
5 habit. You meet people who are nervous such as college
6 students facing examinations who become so tight and nervous
7 and viva voce they can't concentrate, become sick, faint and
8 they have to leave the seminars. These are the kind of
9 problems you see in office practice that you wouldn't see in
10 the hospital.

11 DR. GALLOWAY: I think you clarified that point.
12 Thank you very much.

13 DR. BUTT: Just a couple more questions. In
14 your Association, are they all certified in the specialty.

15 DR. CHALKE: No, they are not.

16 DR. BUTT: What percentage?

17 DR. CHALKE: There are some certified psychiat-
18 rists who are not members of the Association too.

19 DR. BUTT: Do you know what percentage?

20 DR. CHALKE: I think 275 are certified.

21 DR. HENDERSON: The College of Physicians and
22 Surgeons of Ontario registered 242 psychiatrists with specialized
23 certificates. The membership for the Ontario Psychiatric
24 Association is 275 and includes physicians who are specialized
25 in the field of psychiatry and physicians working in related

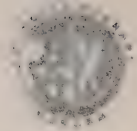
12 DR. CHALKER: No, they are not.



1 fields and a few non medical personnel as well as people in
2 the process of training. There are a number of other people
3 practicing psychiatry, those who are certified in neurology
4 and psychiatry or taken partial training who don't hold the
5 Royal College Special Certificate in addition to the figure
6 of 242.

7 DR. BUTT: In recommendation 2 you discuss the
8 family practitioner. Has he privileges within the Ontario
9 Hospitals? Do you wish him to follow patients outside when
10 you watch them in?

11
12
13
14
15
16
17
18
19
20
21
22
23
24
25



1 I have read the report of the medical committee and find it correct.
2 The committee has recommended that the following be recommended
3 practicing psychiatry. Those who are certified in neurology
4 and psychiatry or taken partial training who don't hold the
5 Royal College Special Certificate in addition to the figure
6 of 242.
7 DR. BUTT: In recommendation 2 you discuss the
8 family practitioner. Has he privileges within the Ontario
9 Hospitals? Do you wish him to follow patients outside when
10 not in the hospital?
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25



DR. CHALKE:

1 I cannot, as a psychiatrist, follow my patients in some Ontario
2 -- most Ontario Hospitals, even as a psychiatrist. General
3 Practitioners are often prevented from following their patients
4 in General Hospital units, not any more, however, than they
5 are prevented from following them in gynecology or obstetrics.
6 This could be because of staff -- the organization of a
7 General Hospital, the psychiatric department located, many of
8 them, in big teaching hospitals where you have staff restric-
9 tions but there is no reason why not. If I may refer to
10 Dr. McKerracher in Saskatchewan, who has been one of the
11 leaders in this. He is working very closely, encouraging his
12 general practitioners in Saskatoon to bring their patients into
13 the psychiatric unit in the University Hospital in Saskatoon
14 and there is a move this way.

15 We have had, in the hospital in which I am
16 associated, two general practitioners assigned to the -- taken
17 from the general medical staff who elected to work in the
18 Department of psychiatry as their public service. There is no
19 rule to keep them out. There are general practitioners working
20 in Ontario Hospitals, doing general medical care. This is
21 something that should be done -- it is not necessary for the
22 psychiatrist to take the sick parade. The family doctor often
23 is a better person to see the cuts and sprains and bad chests,
24 and so there are general practitioners working in Ontario
25 Hospitals.



R. CHAIKIN

1 The first point to be made is that the organization of a
2 -- most Ontario Hospitals, even as a psychiatrist. General
3 hospitals are often organized on the basis of medical specialties.
4 In General Hospital units, and in some, however, first floor
5 are presented in a following form in general as a specialty.
6 This could be because of staff -- the organization of a
7 General Hospital, the psychiatric department, is not at
8 them, in big teaching hospitals where you have staff restric-
9 tions but there is no reason why not. If I may refer to
10 Dr. McKerscher in Saskatchewan, who has been one of the
11 leaders in this. He is working very closely, encouraging his
12 General practitioners to become involved in their patients into
13 the psychiatric unit in the University Hospital in Saskatoon.
14 and there is a need for this.
15 We have had, in the hospital in which I am
16 associated, two general practitioners assigned to the -- taken
17 from the general medical staff who elected to work in the
18 department of psychiatry on their public service. There is no
19 rule to keep them out. There are general practitioners working
20 in Ontario Hospitals, doing general medical care. This is
21 something that should be done -- it is not necessary for the
22 psychiatrist to take the sick parade. The family doctor often
23 is a better person to see the cuts and sprains and bad chests,
24 and so on. The general practitioners working in Ontario
25 Hospitals.



1 DR. BUTT: What is the relationship of this
2 Association with, say, the division of mental hygiene, Depart-
3 ment of Health? In other words, do your members and their
4 ideas coincide? Does your brief and their ideas, do they
5 coincide?

6 DR. CHALKE: Our brief has never been submitted,
7 in a sense officially to the Department of Health. I might
8 say that in preparing this brief, we have had consultation
9 with a number of bodies, including the O.M.A., insurance
10 carriers, and professors of psychiatry in medical schools.
11 However, this is not necessarily their policy.

12 DR. BUTT: Is it their thinking?

13 DR. CHALKE: I think it is. I cannot answer
14 this.

15 DR. BUTT: Could somebody who is related to
16 the---

17 DR. CHALKE: I don't know that-- Mr. Chairman,
18 everybody but myself sitting here is an employee of a Department
19 of Health and I don't know that they should be expected to
20 answer for their Department, for the Government.

21 DR. BUTT: Maybe they can wear another hat at
22 this point and say what they think.

23 DR. HENDERSON: We are doing exactly that sir.
24 We are here as representatives of the Ontario Psychiatric
25 Association.



DR. BUTT: What is the relationship of this

ment of Health? In other words, do your members and their

ideas coincide? Does your brief and their ideas, do they

DR. CHALKER: Our brief has never been submitted,

say that in preparing this brief, we have had consultation

with a number of bodies, including the O.M.A., Insurance

carriers, and professors of psychiatry in medical schools.

However, this is not necessarily their policy.

DR. BUTT: Is it their thinking?

DR. CHALKER: I think it is. I cannot answer

DR. BUTT: Could somebody who is related to

DR. CHALKER: I don't know that-- Mr. Chairman,

everybody but myself sitting here is an employee of a Department

of Health and I don't know that they should be expected to

answer for their Department, for the Government.

DR. BUTT: Maybe they can wear another hat at

this point and say what they think.

MR. KENNEDY: We are doing exactly that sir.

We are here as representatives of the Ontario Psychiatric



1 DR. BUTT: I presume you then feel that the,
2 shall I say the Division of Mental Hygiene will not be adverse
3 to what you have presented?

4 DR. HENDERSON: That is a logical assumption
5 you wish to make.

6 DR. BUTT: Thank you very much for my extracting
7 the information.

8 THE CHAIRMAN: Mr. Simon?

9 MR. SIMON: Do I get this thing right: Because
10 all the doctors in mental hospitals are all resident doctors,
11 they are all on salaries? Is that it?

12 DR. CHALKE: With the exception -- there are
13 people that I mentioned who are two other groups. One, very
14 few, Dr. Moorhouse mentioned coming in and treating the patients
15 in his open unit. There are some psychiatrists who are in
16 practice part time and working on a sessional fee basis,
17 working half days a week in Ontario Hospitals. Then the
18 majority of people are employed full time as members of the
19 Ontario Government Civil Service. They are not resident
20 physicians in the traditional medical meaning of that term.
21 They aren't like internes or house officers in a general
22 hospital. There are some who are in that position but those
23 who are already certified as specialists, may be working full
24 time in Ontario Hospitals.

25 MR. SIMON: When a patient is entered into one



1 DR. BUTT: I presume you then feel that the
2 shall I say the Government of Ontario will not be able
3 to do anything to help them?
4 DR. BUTT: Yes, I think so.
5 you wish to make.
6 DR. BUTT: Thank you very much for my expressing
7 the information.
8 THE CHAIRMAN: Mr. Simon?
9 DR. SIMON: I feel that the Government of Ontario
10 all the better to help them in all their needs.
11 they are all on salaries? Is that it?
12 DR. CHALKER: With the exception -- there are
13 people that I mentioned who are not on salaries, but
14 they are not on salaries, but they are on salaries.
15 in his own right. I think that is all right.
16 practice part time and working on a seasonal fee basis.
17 working half days a week in Ontario Hospitals. Then the
18 majority of people are employed full time as members of the
19 Ontario Government Civil Service. They are not resident
20 hospitals in the Government Civil Service of that kind.
21 they are not in the Government Civil Service in a hospital.
22 hospital. They are not in the Government Civil Service in a hospital.
23 and the only people in hospitals, who are not on salaries,
24 time in Ontario Hospitals.
25 MR. SIMON: When a patient is entered into one



1 of these institutions, is a doctor assigned to that particular
2 patient for the entire period the patient remains?

3 DR. CHAIKE: No. This varies in hospitals.

4 Doctors may be assigned to wards and a patient may be admitted
5 to an admitting ward; treated by the doctor there. Then they
6 get a little bit better and are transferred to another ward --
7 I am painting a rather grim picture as I go on -- but transferred
8 to another ward, have another doctor and may eventually get so
9 they have open privileges on the ground and go and work and
10 so on. Before they are discharged, they are transferred to a
11 third doctor.

12 Now because the superintendent and clinical
13 staff of Ontario Hospitals are acutely aware of this, they
14 do their best to modify this. I think, if I might, ask Dr.
15 Miller to answer how far Ontario Hospitals are able to provide
16 continuous care within the hospital. I mean obviously when
17 the patient leaves the hospital he can't go back. He is not
18 any more a patient of that hospital but may I refer that to
19 Dr. Miller? How far would you provide continuous care under
20 the present setup?

21 DR. MILLER: In our hospital, which is on Queen
22 Street, every patient who comes into hospital is assigned to
23 a doctor who continues the care of that patient until they are
24 discharged or sometimes, if they require long term or chronic
25 care they may be under the care of a physician, but for the



1 of these institutions, in a hospital assigned to that institution
2 outside the entire period the patient remains?

3 DR. CHALKER: No. This varies in hospitals.

4 Patients may be assigned to wards and a patient may be assigned

5 to an institution very, limited by the doctor's staff. Then they

6 get a little bit better and are transferred to another ward --

7 I am quite sure that this is the case as I go on -- but I understand

8 to another ward, where another doctor may eventually get to

9 they have some influence on the ground and go and work and

10 so on. Before they are discharged, they are transferred to a

11 third hospital.

12 Now because the superintendent and clinical

13 staff of Ontario Hospitals are acutely aware of this, they

14 do their best to modify this. I think, if I might, ask Dr.

15 Miller to answer how far Ontario Hospitals are able to provide

16 continuous care within the hospital. I mean obviously when

17 the patient leaves the hospital he can't go back. He is not

18 any more a patient of that hospital but may I refer back to

19 Dr. Miller? How far would you provide continuous care under

20 the present setup?

21 DR. MILLER: In our hospital, which is on Queen

22 Street, every patient who leaves that hospital is assigned to

23 a doctor and continues the care of that patient until they are

24 discharged or admitted, all such patients have some one or other

25 case they are under the care of a physician, but for the



1 most part, I would say that 90% of the patients continue under
2 the care of the doctor who has been assigned to them.

3 MR. SIMON: One more question. Does your
4 Association sincerely believe in the statement made here before
5 that the patient-doctor relationship would be better and the
6 patient would be treated better if a doctor would be paid on a
7 fee for service basis rather than on a salary basis?

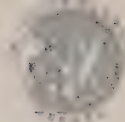
8 DR. CHALKE: Yes.

9 MR. SIMON: I would like to be convinced of that.

10 THE CHAIRMAN: Do you wish to speak further to
11 that?

12 DR. CHALKE: Well all one can point out is that
13 most people, if they are given a choice, will tend to go to
14 a doctor whom they engage and who has undertaken to treat
15 them, before this particular illness. Now one can always point
16 out great exceptions to this; the Armed Forces, and so on; can
17 point out very dedicated service. Now in Ontario Hospitals
18 somehow something can get lost in this kind of arrangement,
19 particularly if administrative requirements overlap clinical
20 requirements, which can happen if you are terribly short of
21 doctors and there are a great number of patients and certain
22 things have to be attended to, the administrative orders, then
23 the patients may suffer.

24 The second thing is there is a tendency -- I
25 speak now from other sources than Ontario Hospital, for



most part, I would say that 90% of the patients continue under the care of the doctor who has been assigned to them.

Association sincerely believe in the statement made here before that the patient-doctor relationship would be better and the patient would be better satisfied if the patient were to be assigned to a particular doctor from the beginning to the end of his illness.

MR. SIMON: I would like to be convinced of that.

THE CHAIRMAN: Do you wish to speak further to that?

that?

DR. CHAIKIN: Well all one can point out is that

them, before this particular illness. Now one can always point

point out very dedicated service. Now in Ontario Hospitals somehow something can get lost in this kind of arrangement, particularly if administrative requirements overlap clinical requirements, which can happen if you are terribly short of doctors and there are a great number of patients and certain things have to be attended to, the administrative orders, then the patients may suffer.

The second thing is there is a tendency -- I

speak now from other sources than Ontario Hospital, for



1 example, D.V.A., that administratively -- a patient who comes
2 to me as a private patient, I feel they need X hours of my
3 time. If I feel they need it day to day, I can make arrange-
4 ments. I can give them this but on a salaried system there is
5 a tendency to sort of set up these work loads. You know, you
6 must see at least three new patients per afternoon and do X
7 hours of psychotherapy with X number of patients and this
8 tendency creeps in and this is what we mean by the patient is
9 not the first consideration in these circumstances.

10 THE CHAIRMAN: Mr. Coulter?

11 MR. COULTER: One more question. At the top of
12 page 12 it says: "In Ontario at present, plans available range
13 from no coverage for treatment through coverage at G.P. rates
14 to unlimited coverage at 90% O.M.A. Schedule (Public Service
15 Plan)." What do you mean by this?

16 DR. CHALKE: Your Public Service Plan sir is the
17 Public Service of Canada. That covers Federal Civil Servants,
18 Armed Forces Dependents and Retired Civil Servants. This is
19 a plan run by Mutual with co-operation of 15 insurance companies
20 in which I think some \$7,000,000. of our Federal Tax money
21 supports the subsidy. It is a plan covering the Federal
22 Civil Servants and they have unlimited psychotherapy at the
23 moment.

24 THE CHAIRMAN: Dr. Chalke, am I right in under-
25 standing you to infer that in psychoanalysis it may require



1 I am not sure that this is a problem for me.
2 I am not sure that this is a problem for me.
3 time. If I feel they need it day to day, I can make arrange-
4 ments. I can give them all the help they need. I can make
5 a tendency to sort of set up these work loads. You know, you
6 must not be least of all. I am not sure that this is a
7 problem of responsibility with a number of patients and this
8 is a problem of responsibility with a number of patients. It
9 is not the first consideration in these circumstances.

10 THE CHAIRMAN: Mr. Gault?

11 MR. GALT: One more question. At the top of

12 to unlimited coverage at 90% O.M.A. Schedule (Public Service
13 Plan). What do you mean by this?

14 DR. CHALKER: Your Public Service Plan is the

15 supports the subsidy. It is a plan covering the Federal

16 I am not sure that this is a problem for me.



1 four to five times 50 hours?

2 DR. CHALKE: Yes sir.

3 THE CHAIRMAN: Does that need to be done
4 continuously or could it be taken in different periods?

5 DR. CHALKE: No. Psychoanalysis is organized
6 as a continuous -- day after day, one hour a day, eight to
7 nine in the morning for a year or two years, every morning,
8 five days a week.

9 Now this is a rare form of treatment and one
10 that is not widely developed or used. It is one that under
11 the National Health Service of England is covered in fact,
12 but they have only got about four analysts working in the whole
13 National Service; only covers 32 patients so it isn't scaring
14 one of the insurance companies. Really it's rare.

15 THE CHAIRMAN: My reason for asking the question:
16 When you say 50 hours per annum, if this limits it to 50,
17 if it is on a calendar basis, that could mean 100 contact
18 hours. In other words, you could get continuous treatment in
19 two calendar years of 100 contact hours. If it is on a 12-
20 month basis, why then you couldn't have continuous treatment.

21 DR. CHALKE: We have made it this elastic. We
22 felt it was not necessary to put it on the one a week basis.
23 This would restrict us to a certain extent because you do see
24 the odd person acutely ill. I had somebody recently who had a
25 job in the Government requiring him to fly in an aeroplane and

1 four to five times 50 hours?

2 DR. CHALKER: Yes, sir.

3 THE CHAIRMAN: Does that need to be done

4 continuously or could it be taken in different periods?

5 DR. CHALKER: No. Psychoanalysis is organized

6 as a continuous -- day after day, one hour a day, eight to

7 nine in the morning for a year or two years, every morning.

8 five days a week.

9 Now this is a rare form of treatment and one

10 that is not done in the United States. It is done in London

11 and in the National Institute of Mental Health in Washington.

12 but they have only got about four analysts working in the whole

13 National Service; only covers 32 patients so it isn't scoring

14 one of the insurance companies. Really it's rare.

15 THE CHAIRMAN: My reason for asking the question

16 is that I have heard that the British are doing it in the

17 United States, and I am interested in the results of it.

18 I am interested in the results of it, and I am interested in the

19 two calendar years of 100 contact hours. If it is on a 12-

20 month basis, why then you couldn't have continuous treatment.

21 DR. CHALKER: We have made it this elastic. We

22 felt it was not necessary to put it on the one a week basis.

23 I have heard that the British are doing it in the United States

24 the odd person suddenly ill. I had somebody recently who had a

25 job in the Government requiring him to fly in an aeroplane and



1 suddenly got a panic about planes. Now they had to be treated
2 fairly quickly because public duty required them to get away
3 again fairly soon and had to see them three times a week for
4 three months to get the thing cleared up so that it is possible
5 you may have to give your 50 hours, under certain circumstances,
6 concentrated and it would seem to me unfair for the acute
7 illness to say we can only -- your insurance will only cover
8 if you spread this over a whole year but for many patients it
9 would be once a week. I would take a majority of patients,
10 under 50 interviews a year, give them once a week type of plan
11 rather than an exception. We did not want to exclude that
12 coverage.

13 THE CHAIRMAN: Any other questions.

14 MR. MAJOR: Was that bill paid under insurance?

15 DR. CHALKE: Yes.

16 MR. MAJOR: I thought most insurance policies
17 had a clause in them that any medical care required by the
18 employer, the employer was to pay for it? Was this being
19 acquired by the employer?

20 THE CHAIRMAN: This is a technical question that
21 really has no relation to Bill 163.

22 DR. CHALKE: They had to be good enough to do
23 their job.

24 MR. CASWELL: A particular person requiring
25 psychoanalysis treatment, is that by a psychiatrist?



1 I am not a family doctor. The fact that I am a family
2 doctor does not mean that I am not a family doctor. I
3 again fairly soon and had to see them three times a week for
4 three months to get the thing cleared up so that it is possible
5 and not have to give you 20 hours a week. I am not a family
6 doctor and it would seem to me unfair for the acute
7 illness to say we can only -- your insurance will only cover
8 in your case a whole year but the way you are
9 would be to say that I would have a whole year of
10 to say that I would have a whole year of
11 rather than an exception. We did not want to exclude that

12 THE CHAIRMAN: Any other questions.

13 MR. MAJOR: Was that bill paid under insurance?

14 DR. CHALKER: Yes.

15 MR. MAJOR: I thought most insurance policies

16 had a clause in them that any medical care required by the

17 employer, the employer was to pay for it? Was this being

18 acquired by the employer?

19 THE CHAIRMAN: This is a technical question that

20 DR. CHALKER: They had to be good enough to do

21 their job.

22 MR. CASWELL: A particular person requiring

23 psychoanalytic treatment, is that by a psychiatrist?



1 DR. CHALKE: Usually.

2 MR. CASWELL: Did I understand you to say there
3 are only eight in Toronto who give psychoanalysis?

4 DR. CHALKE: I am not even sure there are even
5 eight.

6 MR. GRAY: I don't think there are that many.

7 DR. CHALKE: Six possibly and some of these are
8 not -- they are not all devoting their full time to psycho-
9 analysis. Some of them are teachers in Universities part time
10 and have other jobs.

11 MR. CASWELL: After you are a psychiatrist you
12 have to have further teaching and training to be a psycho-
13 analyst?

14 DR. CHALKE: That is correct, yes, another three
15 or four years beyond your five years post-graduate.

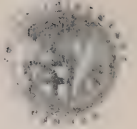
16 MR. MAJOR: What is the basis of that Dr. Chalke ?
17 Is psychoanalysis basically under a hypnotic of some kind?
18 Why do you need the extra training? Is this basically,
19 psychoanalysis, performed under some type of hypnotic, either
20 drug or otherwise?

21 DR. CHALKE: No, quite the reverse. It never is.

22 MR. MAJOR: Matter of suggestion?

23 DR. CHALKE: No, it is a matter of exploring
24 your own motives for doing things, to put it in a nutshell.

25 THE CHAIRMAN: Takes three years to learn the



DR. CHAIKIN: CHAIRMAN

MR. CASWELL: Did I understand you to say there

are only eight in Toronto who give psychoanalyses?

DR. CHAIKIN: I am not even sure there are even

eight.

MR. GRAY: I don't think there are that many.

DR. CHAIKIN: Six possibly and some of these are

not — they are not all doing it full time or even

part-time, some of them are doing it part-time and some

and have other jobs.

MR. CASWELL: After you are a psychiatrist you

have to have further training and training to be a psycho-

analyst?

DR. CHAIKIN: That is correct, yes, another three

or four years beyond your five years post-graduate.

MR. MAJOR: What is the basis of that Dr. Chaikin?

Is psychoanalysts basically under a hypnotic of some kind?

Why do you need the extra training? Is this basically,

psychoanalysts, are they not just a group of hypnotists?

bring on otherwise?

DR. CHAIKIN: No, quite the reverse. It never is.

MR. MAJOR: Matter of suggestion?

DR. CHAIKIN: No, it is a matter of exploring

your own motives for doing things, but it is a matter of

THE CHAIRMAN: Takes three years to learn the



1 answer to that question.

2 MR. CASWELL: It's a matter of the right couch.

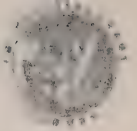
3 MR. MAJOR: I wonder if you could help me a little
4 bit to clarify some of these things. What I am trying to get
5 is the scope of this problem as far as an insurance applica-
6 tion is concerned and when we are speaking of crippling
7 psychosis, does this mean that actually there will be, for
8 an indefinite period of time, an institution which will have
9 to take care of these people? That they just can't get out of
10 there? Let's take the homicidal maniac who cannot be cured.
11 Is he going to stay there forever and a day?

12 DR. CHALKE: There are some, yes, just as there
13 are some people with strokes and arthritis who never get out
14 of chronic disease hospitals. There are some because we cannot
15 get them well enough that they ever can get away from having
16 nursing care.

17 MR. MAJOR: This will be a certain percent of
18 the 50% of the people that evidently start out in private
19 practice with a general practitioner, so that a percentage of
20 these people will eventually end up in an institution and stay
21 there because of the crippling disease and brain diseases, or
22 something like that?

23 DR. CHALKE: This is true. I am sorry, I did
24 not get your reference to 50%.

25 MR. MAJOR: You said that possibly 50% of general



1.

2. MR. CASWELL: It's a matter of the right corner.

3. MR. MAJOR: I wonder if you could help me a little

4. bit to clarify some of these things. What I am trying to get

5. is the scope of this problem as far as an insurance applica-

6. tion is concerned and what are the results of applying

7. psychotics, does this mean that actually there will be, for

8. the purpose of the law, a facility which will have

9. to the care of these people? That they can't get out of

10. there? Let's take the homicidal maniac who cannot be cured.

11. Is he going to stay there forever and a day?

12. DR. CHAIKIN: There are some, yes, just as there

13. are some people with alcoholism who never get out

14. of alcoholism and hospitalization. There are some because we cannot

15. get them well enough that they can get away from hospital

16. nursing care.

17. MR. MAJOR: This will be a certain percent of

18. the 50% of the people that evidently start out in private

19. practice with a general practitioner, so that a percentage of

20. these people will eventually end up in an institution and stay

21. there because of the chronic illness and other diseases, or

22. something like that?

23. DR. CHAIKIN: This is true. I am sorry, I did

24. not get your reference to 50%.

25. MR. MAJOR: You said that possibly 50% of general



1 practitioners' practice was doing neurosis of some kind.

2 DR. CHALKE: I said these are very often what we
3 call psychosomatic disorders. A person comes in with an
4 outburst of ulcers brought on by business stress.

5 MR. MAJOR: You have to take my terminology in
6 its broadest sense.

7 DR. CHALKE: I did not say 50% of practitioners
8 were dealing with crippling psychosis.

9 MR. MAJOR: If you start all these people through
10 general practitioners, certainly they will eventually end up,
11 because of the crippling situation, in this Institution for
12 the rest of their lives.

13 DR. CHALKE: That is right. It would be very
14 small.

15 MR. MAJOR: Might be very small, might be big.
16 The psychiatrist that is looking after these people, is it your
17 intention then that psychiatrists be on a salary or that they
18 practice on a fee for service basis with these people?

19 DR. CHALKE: Well this is really going back to
20 Mrs. Aylen's question. We are not really happy because, you
21 see, out of any one psychiatrist, say practising in Toronto,
22 you have got Whitby, 999 Queen Street, New Toronto, taking care
23 of psychiatric -- plus your general hospital, may end up with
24 150 psychiatrists in Toronto and environs, and we ought to,
25 might have two patients who were in this unrecoverable crippling

outburst of ulcers brought on by business stress.

were dealing with crippling psychoses.

DR. CHAIKIN: That is right. It would be very
the rest of their lives.

• 116 mg

MR. MAJOR: Might be very small, might be big.

practice on a fee for service basis with these people?

DR. CHAIKIN: Well this is really going back to

you have got Whitty, 999 Queen Street, New Toronto, taking care
see, out of any one psychiatrist, say practising in Toronto,

of psychiatric -- plus your general hospital, may end up with

100 copies available in Toronto and elsewhere, and an output of

which have two sections one wide in this direction and the other



1 psychosis position we are talking about. Now whether it is
2 better for them to each be responsible for going and visiting
3 their patient once a month in whatever chronic care institution
4 they are in, or whether they would be happy to turn them all
5 over to Dr. X, who is an expert in caring for chronic patients,
6 and have him visit them each once every two weeks, I don't think
7 we can answer.

8 MR. MAJOR: I understand. Let's go back and see where
9 in the principle of insurance, that a risk must be determin-
10 able, leads us. It is very simple to insure cholecystectomy and
11 neuro-surgery because we can see a start and an end to this and
12 we know it is not elective, although there may be some surgery
13 elective but we can see an end to this by experience and also
14 we can see an end to cases of pneumonia or the heart attack and
15 so on down the line. How do you see an end, from the insurance
16 point of view, to this particular person that you are talking
17 about if we put a doctor on a fee for service basis where he
18 must see this patient once or twice a month for ever.

19 DR. CHALKE: I do not see an end to this particular
20 group, any more than you do for the progressive rheumatoid
21 arthritis, the diabetic. You do not see an end to that or the
22 progressive disseminated sclerosis. In this group you are
23 talking about, they are not all psychiatric cases, but the ones
24 who are chronic and aren't going to get better are the
25 arteriolosclerosis, and so on. The only thing you can predict



1 psychosis position we are talking about. Now whether it is
2 better for the patient to have the disease and visit
3 the doctor or to have the disease and not visit
4 the doctor, or to have the disease and not visit
5 over to Dr. X, who is an expert in caring for chronic patients,
6 and have him visit them each once every two weeks, I don't think
7 we can answer.
8 MR. MAJOR: I understand. Let's go back and see where
9 in the principle of insurance, that a risk must be determin-
10 able, leads us. It is very simple to understand that a risk must
11 be determinable, and we can see an end to this by experience and also
12 we know it is not determinable, and we can see an end to this by experience and also
13 effective but we can see an end to this by experience and also
14 we can see an end to cases of pneumonia or the heart attack and
15 so on down the line. How do you see an end, from the insurance
16 point of view, to this particular person that you are talking
17 about if we put a doctor on a fee for service basis where he
18 must see this patient once or twice a month for ever.
19 DR. CHALKER: I do not see an end to this particular
20 group, any more than you do for the progressive rheumatoid
21 arthritis, the diabetic. You do not see an end to that or the
22 progressive disseminated sclerosis. In this group you are
23 talking about, and you see all these cases, and you see
24 who are chronic and aren't going to get better and the
25



1 on is the rate per thousand per annum. You will expect to
2 get three new cases per thousand of some unrecoverable illness
3 which will give you some psychiatric.

4 MR. MAJOR: As far as you are concerned this
5 approach should be coverable by insurance?

6 DR. CHALKE: Yes.

7 MR. MAJOR: You said that one of the reasons that
8 insurance was hesitant about this was they did not know enough
9 about it. Maybe you could turn it around and say that insurance
10 has learned enough about psychiatric care they are hesitant
11 about it. It can work both ways.

12 Coming back to something else that has come out
13 in the question and answer period, do you think there is any
14 curative value in the taking of a dollar from a psychiatric
15 patient?

16 DR. CHALKE: Curative value? No, not curative.

17 MR. MAJOR: Is there anything ~~palliative~~ about it?
18 Does charging a psychiatric patient a fee help him to recover?

19 DR. CHALKE: Yes. It may help him -- well this
20 is a bit of a technical question really. There is a complica-
21 tion there. There is such a thing as human dependency and
22 people like to, sometimes, some patients like to be dependent
23 on other people. Now this is a complication of psychiatric
24 treatment, like infection is sometimes a complication of
25 surgery. You don't want it to happen but it sometimes gets in



on is the rate per thousand per annum. You will expect to

and three new cases per thousand per annum. I don't know whether it is

which will give you some psychiatric.

MR. MAJOR: As far as you are concerned this

approach should be coverable by insurance?

DR. CHALKER: Yes.

MR. MAJOR: You said that one of the reasons that

insurance was hesitant about this was they did not know enough

about it. Maybe you could turn it around and say that insurance

has learned enough about psychiatric care they are hesitant

about it. It can work both ways.

Coming back to something else that has come out

is the question of the value of the psychiatric

curative value in the taking of a dollar from a psychiatric

patient.

DR. CHALKER: Curative value is a very

MR. MAJOR: Is there anything qualitative about it?

DR. CHALKER: Yes. It may help him -- well this

is a bit of a technical question really. There is a complica-

tion there. There is such a thing as human dependency and

people like to, sometimes, some patients like to be dependent

on other people. Now this is a complication of psychiatric

treatment, like infection is sometimes a complication of

surgery. You don't want it to happen but it sometimes gets in



1 the way there and you have got to get rid of it.

2 One way of preventing overdependency is to
3 continue to get that person in a responsible position.

4 Responsibility means you are taking part in this too.

5 MR. MAJOR: And sharing in the cost is taking
6 part in it?

7 DR. CHALKE: It is symbollically taking part in
8 it.

9 MR. MAJOR: It's the mental mechanism that must
10 be -- if the patient is worth treating at all, this patient
11 must have this mental mechanism to understand what payment
12 means. Right?

13 DR. CHALKE: Yes.

14 MR. MAJOR: So it has a curative value?

15 DR. CHALKE: Yes.

16 MR. MAJOR: That kind of illogical logic. Now
17 let's go down to another phase of this. Mental and emotional
18 illness, of course, has a very very broad scope and I think
19 you pointed out very well how the general practitioner handles
20 it. Now would it seem reasonable then that all psychiatric
21 services under insurance should only be paid for if the patient
22 was professionally referred to the psychiatrist?

23 DR. CHALKE: We would certainly go along with
24 that.

25 MR. MAJOR: That is a reasonable principle?



1. ... and ...

2. ...

3. ...

4. ... responsibility means you are taking part in this too.

5. MR. MAJOR: And sharing in the cost is taking

6. part in it?

7. DR. CHALKER: It is symbolically taking part in

8. MR. MAJOR: It's the mental mechanism that must

9. must have this mental mechanism to understand what payment

10. means. Right?

11. MR. MAJOR: So it has a curative value?

12. DR. CHALKER: Yes.

13. MR. MAJOR: That kind of illogical logic. Now

14. let's go down to another phase of this. Mental and emotional

15. illness, of course, has a very broad scope and I think

16. you pointed out very well how the general practitioner handles

17. it. Now would it seem reasonable then that all psychiatric

18. services under insurance should only be paid for if the patient

19. was professionally referred to the psychiatrist?

20. DR. CHALKER: We would certainly go along with

21. MR. MAJOR: That is a reasonable principle?



1 DR. CHALKE: That is a reasonable principle, yes.

2 MR. MAJOR: Thank you. Now there is a statement
3 I wonder if you could enlarge upon for me, on page 6, paragraph
4 d where it says: "It is recognized that the responsibility for
5 further progress in the integration of the practice of
6 psychiatry into general medicine does not rest solely with the
7 carriers of medical care insurance." I am interested in this.
8 What does this statement mean?

9 DR. CHALKE: This is the first sentence you
10 read?

11 MR. MAJOR: Yes. It doesn't rest solely with the
12 carriers of medical care insurance.

13 DR. CHALKE: Because we have said up above that
14 this integration is taking place now and when we have been
15 talking to various people, sometimes -- I don't want to say
16 there are agencies, but people have said you can't expect the
17 insurance companies to carry your ball for you. If you people
18 want to get back into medicine, you have got to do the
19 organization, make representations, make changes. You can't
20 expect us to fight your battle and all we are saying is we
21 don't want the insurance companies to stop this progress. We
22 don't think they are responsible for encouraging it at all.
23 It is up to us to encourage it.

24 MR. MAJOR: By the way Dr. Chalke, mental illness,
25 is it contagious in any way?



DR. CHALKER: That is a reasonable principle, yes.

MR. MAJOR: Thank you. Now there is a statement

Further progress in the integration of the practice of

psychiatry into general medicine does not rest solely with the

carriers of medical care insurance." I am interested in this.

What does this statement mean?

DR. CHALKER: This is the first sentence you

read?

MR. MAJOR: Yes. It doesn't rest solely with the

carriers of medical care insurance.

DR. CHALKER: Because we have said up above that

the integration is a long process and we have been

talking to various people, sometimes -- I don't want to say

there are agencies, but people have said you can't expect the

insurance companies to carry your bill for you. If you people

want to get back into medicine, you have got to do the

work, and you have got to be prepared to do it.

expect us to fight your battle and all we are saying is we

don't want the insurance companies to stop this progress. We

don't think they are responsible for encouraging it at all.

It is up to us to encourage it.

is it contagious in any way?



1 DR. CHALKE: Is it contagious?

2 MR. MAJOR: Yes.

3 DR. CHALKE: Some contagious diseases have mental
4 illness complications. Encephalitis, neuro-syphilllis are
5 contagious diseases which lead to mental disorders.

6 MR. MAJOR: I am trying to understand the
7 proposition that you must keep this person on a fee for service
8 basis because it is good for the person, in relation to, say,
9 the tubercular patient who is also in a T.B. hospital--I
10 gather because this is a contagious disease. This may not be
11 so but that is in my mind, and as far as I know the general
12 practitioner puts a patient into a T.B. hospital and doesn't
13 go to see that patient, although he could do so. Now I gather
14 that, although you say there are no rules against it, the
15 family physician going to see the patient in a mental hospital,
16 he is deterred from doing so.

17 DR. CHALKE: He is not deterred by the hospital.
18 He is deterred by -- in fact, the hospital would fall over in
19 delight if he came. He is deterred often by his own
20 strenuous life and the 50, 60, mile distance to the hospital.

21 MR. MAJOR: Thank you. There is no reason why
22 the psychiatric patient should be isolated?

23 DR. CHALKE: No.

24 MR. MAJOR: Then the old fashioned worry about
25 we don't want him loose in society is no longer---



DR. CHAIKIN: Is it contagious?

DR. CHAIKIN: Some contagious diseases have mental

illness complications. Pneumonia, neuro-syphilis are

contagious diseases which lead to mental disorders.

MR. MAJOR: I am trying to understand the

association that you have said between the two for

basis because it is good for the person, in relation to, say,

the tubercular patient who is also in a T.B. hospital--

gather because this is a contagious disease. This may not be

so but that is in my mind, and as far as I know the general

impression is that a patient in a T.B. hospital is

go to see that patient, although he could do so. Now I gather

that, although you say there are no rules against it, the

fact is that a patient in a T.B. hospital is not to be

in the hospital.

DR. CHAIKIN: He is not deterred by the hospital.

He is deterred by the hospital.

delight if he came. He is deterred often by his own

strenuous life and the 50, 60, mile distance to the hospital.

MR. MAJOR: Thank you. There is no reason why

the psychiatric patient should be isolated?

MR. MAJOR:

Then the old fashioned worry about

we don't want him loose in society is no longer--



1 DR. CHALKE: No. There was nobody who was trying
2 to treat this patient before. All they were trying to do is
3 to give him custodial care. The doctor-patient relationship
4 did not exist. This was just custodial care 75 years ago when
5 it started.

6 MR. MAJOR: Along with the thinking of the 50
7 hours, seems a lot on the basis that the average is 8 to 10,
8 why wouldn't we just double it? Say the doubling of this
9 average is sufficient. You want the 50 hours for what reason?

10 DR. CHALKE: If I may draw a parallel, sir, the
11 average for an appendectomy is \$75.00, or something. The brain
12 tumour operations are much rarer than an appendectomy and the
13 fee is different. Now there is a small group of patients who
14 need 50 hours but it would seem to us that that group of
15 patients are in greatest need of insurance coverage because
16 this is a pretty catastrophic thing, so that we felt we had to
17 cover the small number where it is really necessary, if they
18 are going to be adequately treated medically.

19 MR. MAJOR: How would we control that? Let me
20 give you an example of what is going through my mind. Let's
21 take the businessman who is holding down a responsible job,
22 and I don't mean a man who is afraid of flying. I am practically
23 as bad as he is but I haven't got nerve enough to go to a
24 psychiatrist about it, but here is a manager or a supervisor
25 and I am not talking theories doctor, I am talking facts, who



1 DR. CHAIKIN: No. There was nobody who was trying
2 to treat this patient before. All they were trying to do is
3 to give him custodial care. The custodial relationship
4 did not exist. This was just custodial care 75 years ago when
5 it started.
6 MR. MAJOR: Along with the thinking of the 50
7 years, there's a lot of time that the average is 3 to 10,
8 why wouldn't we just double it? Say the doubling of this
9 average is 10 years. You want to know for what reason?
10 DR. CHAIKIN: If I may draw a parallel, sir, the
11 average for an operation is 15,000 or something. The price
12 of an operation is much more than an operation and the
13 fee is different. Now there is a small group of patients who
14 need 50 hours but it would seem to us that that group of
15 patients are in greatest need of intensive therapy because
16 this is a great, extraordinary thing and that we have to
17 cover the small number where it is really necessary, it isn't
18 are going to be adequately treated medically.
19 MR. MAJOR: How would we control that? Let me
20 give you an example of what is going through my mind. Let's
21 take the businessman who is holding down a responsible job,
22 and I want to see the in terms of living. I am practically
23 as bad as he is but I haven't got nerve enough to go to a
24 psychiatrist about it. But here is a man who is a supervisor
25 and I am not taking specific action, I am taking action, who



1 requires treatment from a psychiatrist once a week to carry on
2 his job.

3 Now in normal circumstances, in the principle
4 of insurance, I don't think the insurance company would take
5 very kindly to being a crutch. Either this man has gone up the
6 ladder too far, or something is wrong, if he maintains that he
7 has to have this treatment to carry on his job. How do we
8 control this kind of thing in psychiatry and we have the
9 problem at our table.

10 DR. CHALKE: I think that this would have to be
11 controlled in certain specific cases by simple clarification
12 but if I may take a parallel: Suppose somebody has pernicious
13 anemia and has to go and have a shot of vitamin B-12 to stay on
14 their job. You wouldn't say he shouldn't go and get his
15 medical treatment and keep him at work?

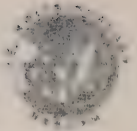
16 MR. MAJOR: No. There is a great deal of
17 difference, of course, between the cost of a shot of B-12 and
18 psychiatric treatment.

19 DR. CHALKE: Right. Well I think that if it can
20 be shown that this is not an illness, then I think we should not
21 be covered by a medical care insurance plan.

22 MR. MAJOR: Sort of like cosmetic surgery. If
23 this has become a hobby, we should stop paying for it.

24 DR. CHALKE: Quite right.

25 MR. MAJOR: On page 13 you recommend limits to



1 receiving treatment from a psychiatrist once a week in hospital.
2 his job.
3 Now in normal circumstances, in the principle
4 of management, I don't think the insurance company would
5 very kindly be being a creditor. Right. This was done up the
6 ladder for him, or something like that. It was suggested that he
7 has to have this treatment to carry on his job. How do we
8 control this kind of thing in psychiatry and we have the
9 position at our table.
10 DR. CHALKER: I think that this would have to be
11 controlled in certain specific cases by clinical observation.
12 but if I may take a parallel: suppose someone has a condition
13 which affects his work and have a lot of trouble in it, or on
14 their job. You wouldn't say he shouldn't go and get his
15 medical treatment and keep him at work?
16 MR. MAJOR: No. There is a great deal of
17 difference, of course, between the cost of a lot of pills and
18 psychiatric treatment.
19 DR. CHALKER: Right. Well I think that it is our
20 job to show that this is not an illness, then, I think we should
21 be advised by a medical or psychiatric firm.
22 MR. MAJOR: Sort of like cosmetic surgery. If
23 this has become a hobby, we should stop paying for it.
24 DR. CHALKER: Quite right.
25 MR. MAJOR: On page 13 you recommend limits to



1 the equivalent of 50 hours. Why don't we turn this around
2 and say that we will not pay for the first \$500.00 worth of
3 psychotherapy. From there on we will pay. This would be an
4 excellent deterrent wouldn't it rather than cutting the person off
5 that needs it at 50 hours.

6 DR. CHALKE: This is a new deterrent approach
7 to psychotherapy.

8 MR. MAJOR: I am thinking of that sort of
9 illogical logic that we developed. By paying, you are going
10 to get them often. You see what I mean? If you start
11 charging them from the first day at \$20.00 an hour they will
12 either stay crazy or pay the money until they have reached---

13 DR. CHALKE: Until they qualify for their
14 insurance.

15 MR. MAJOR: These are the kind of things, Dr.
16 Chalke, that the insurance companies try to reconcile here.

17 DR. CHALKE: I would go along entirely with this
18 if we apply it to the rest of medicine. If this is true there,
19 it is equally true for the lady who goes in every day to get
20 her back adjusted.

21 MR. MAJOR: Isn't there a little difference --
22 a chap who has a broken leg. No amount of dollars is going to
23 change this trauma that he has suffered. His thinking process
24 is not equivalent to the fellow whose thinking process is I
25 need somebody to tell me how to think. This fellow knows how



1 the equivalent of 50 hours. Why don't we turn this around

2 and say that we will not pay for the first \$500.00 worth of

3 physiotherapy. From that on we will pay. This would be an

4 excellent incentive system. It is rather than having the person off

5 that needs it at 50 hours.

6 DR. CHAIKE: This is a new deterrent approach

7 MR. MAJOR: I am thinking of that sort of

8 illogical logic that we developed. By paying, you are going

9 to get them often. You see what I mean? If you start

10 charging them from the first day at \$20.00 a hour they will

11 DR. CHAIKE: Until they qualify for their

12 insurance.

13 MR. MAJOR: These are the kind of things, Dr.

14 Chaiken, that the insurance companies try to reconcile here.

15 DR. CHAIKE: I would go along entirely with this

16 if we apply it to the rest of medicine. If this is true there,

17 it is equally true for the lady who goes in every day to get

18 her back adjusted.

19 MR. MAJOR: Isn't there a little difference --

20 a chap who has a broken leg. No amount of dollars is going to

21 change this trauma that he has suffered. His thinking process

22 need somebody to tell me how to think. This fellow knows how



1 to think. He is perfectly rational but has got a broken leg.

2 Now this is a different thinking process isn't it?

3 DR. CHALKE: What about the man who has the
4 broken leg and continues to be unable to walk on it, and the
5 Compensation Board says I think that this is because he is
6 getting compensation from us and we would like him to have
7 psychiatric treatment and there are lots of people referred
8 with simple physical disabilities by the Compensation Board in
9 order to get their psyche straightened out so they will use
10 their broken leg again.

11 MR. MAJOR: You are a tough man to argue with.
12 Let us come down to some cost figures. On page 17 we talk
13 about 18,000 patients in 1961 for an average of 19 days for a
14 total million and a half dollars. I am not quite sure of my
15 decimal point but it looks to me as though it works out at
16 \$4.50 per patient day.

17 DR. CHALKE: That is right. This was calculated
18 on O.M.A. rates.

19 MR. MAJOR: Hospital visits.

20 DR. CHALKE: Hospital visits.

21 MR. MAJOR: Not psychiatric treatment.

22 DR. CHALKE: The treatment in hospital -- the
23 18,000 weren't all in psychiatric institutions treated by
24 psychiatrists. 13,000 were treated by general practitioners in
25 general hospitals. Only 5,000 were psychiatric treatment. Some



1. ... is perfectly ... but not a broken leg.

2. ... is a different ... process ...

3. DR. CHALKER: What about the man who has the

4. ... and ... to walk on it, and the

5. ... says ... in ...

6. ... compensation ...

7. ... and ...

8. ... in

9. order to get their payche strengthened out so they will use

10. their broken leg again.

11. MR. MAJOR: You are a tough man to argue with.

12. Let us come down to some cost figures. On page 17 we talk

13. about ...

14. total million and a half dollars. I am not quite sure of my

15. decimal point but it looks to me as though it works out at

16. \$4.50 per patient day.

17. DR. CHALKER: That is right. This was calculated

18. on O.M.A. rates.

19. MR. MAJOR: Hospital visits.

20. ...

21. MR. MAJOR: Not psychiatric treatment.

22. DR. CHALKER: The treatment in hospital -- the

23. ...

24. ...

25. ...



1 were charged \$3.00 a day, the general practice rate.

2 MR. MAJOR: In other words there must be a
3 different category of statistics used is this than what is
4 used in insurance. If the general practitioner looked after
5 psychiatric needs in a hospital and termed it some other term
6 -- dermatitis, but actually it is psychiatry. This wouldn't
7 fall into our statistics. Are we talking about this kind of
8 thing.

9 DR. CHALKE: This is Ontario Hospital Service
10 figures, O.H.S.C. On their discharge they had diagnosis, a
11 psychiatric diagnosis on 18,000.

12 MR. MAJOR: This covers all hospitals in their
13 jurisdiction in Ontario.

14 DR. CHALKE: O.H.S.C. figures include 5,000
15 treated in psychiatric units of general hospitals.

16 MR. MAJOR: That covers \$4.00. Now, on page
17 21 the average income of about \$20,000 for each psychiatrist.
18 This is gross income we are talking about?

19 DR. CHALKE: It would be, yes.

20 MR. MAJOR: Approximately 30% to 40% for business
21 expenses, is it as high as that?

22 DR. CHALKE: It isn't as high.

23 MR. MAJOR: Psychiatrists, possibly 30%.

24 DR. CHALKE: I think approximately 30.

25 MR. MAJOR: So out of \$20,000. after 12 years of



1. ... 1950 ...
2. MR. MAJOR: In other words there must be a
3. ...
4. ...
5. psychiatric needs in a hospital and termed it some other term
6. ...
7. ...
8. ...
9. MR. MAJOR: ...
10. figures, O.H.S.C. On their discharge they had diagnosis, a
11. psychiatric diagnosis on 18,000.
12. MR. MAJOR: This covers all hospitals in their
13. jurisdiction in Ontario.
14. DR. CHALKER: O.H.S.C. figures include 5,000
15. treated in psychiatric units of general hospitals.
16. MR. MAJOR: That covers \$4.00. Now, on page
17. ...
18. ...
19. ...
20. MR. MAJOR: Approximately 30% to 40% for business
21. ...
22. DR. CHALKER: It isn't as high.
23. MR. MAJOR: Psychiatric, possibly 30%.
24. DR. CHALKER: I think approximately 30.
25. MR. MAJOR: So out of \$20,000, after 12 years of



1 academic brow-beating he only ends up with \$14,000.

2 DR. CHALKE: I would hate to tell you, sir,
3 what most of the psychiatrists are getting working for most of
4 the people of Ontario. If you look at the Civil Service rates
5 they are far less than that.

6 MR. MAJOR: Somebody asked a question as to
7 whether or not the psychiatric field wasn't attractive because
8 they weren't paid enough. I would suggest this may be very
9 important. On the other hand at \$12,000,000. with 300
10 psychiatrists this gives us something like \$40,000. worth of
11 psychiatry.

12 DR. CHALKE: That is why we said we feel
13 insurance funds will be fairly well protected because it will
14 take us a long time to be able to utilize them.

15 MR. MAJOR: Have you any statistics of what
16 psychiatrists earn in private practice, a man exclusively in
17 private practice, doing work directly in private practice.

18 DR. CHALKE: I know what some psychiatrists are
19 making. I don't think any of us have an average except what
20 we would get from the income tax statistics.

21 MR. MAJOR: Are you acquainted with a study
22 made by the Canadian Medical Association Journal approximately
23 1959. I am not sure of the month. It might have been May,
24 where it set forth the average psychiatric practice in a
25 2,000 hour year of rendering approximately 4200 to 4300 services



1 academic brow-beating he only ends up with \$14,000.

2 DR. CHALKER: I would hate to tell you, sir,

3 what sort of a person this was. I would hate to tell you, sir,

4 the people of Ontario. It was a very good thing that the Civil Service

5 was not too late to get it.

6 MR. MAJOR: Somebody asked a question as to

7 whether or not the government would make a retrospective payment

8 that somebody said would be \$12,000,000. I would suggest this may be very

9 important. On the other hand at \$12,000,000, with 300

10 psychiatrists this gives us something like \$40,000,000, which is

11 a very large sum.

12 DR. CHALKER: That is why we said we feel

13 that the government will be fairly well covered because it will

14 take us a long time to be able to utilize them.

15 MR. MAJOR: Have you any statistics of what

16 psychiatrists are in private practice, a man exclusively in

17 private practice, or work directly in private practice,

18 DR. CHALKER: I know what some psychiatrists are

19 making. I don't think any of us have an average except what

20 we would get from the income tax statistics.

21 MR. MAJOR: Are you acquainted with a study

22 made by the Canadian Medical Association Journal approximately

23 1959. I am not sure of the month. It might have been May,

24 when it was found that average psychiatric practice in a

25 2,000 hour year of service approximately \$200 to \$300 service



1 in that year -- does this study come back to your mind?
2 That study set forth something like 450 consultations a year
3 and over 2,000 psychiatric treatments and so on. It also
4 includes a certain number of hospital calls, office calls of
5 routine basis. It was estimated on cost per service in
6 psychiatry along this type of field would bring somewhere from
7 \$9.00 to \$10.00 a treatment and this would bring approximately
8 \$40,000. a year income for the psychiatrist in private practice.

9 DR. CHALKE: There are psychiatrists who are
10 making this. They are few and exceptional because you also
11 have to consider, sir, that most of these psychiatrists are
12 on the staffs of general hospitals. They must have public
13 service. That takes you two mornings a week. You may have
14 to give lecture classes. You may have to sit on two hospital
15 Committees. It is a very exceptional psychiatrist who is
16 earning eight in the morning to six at night. You could
17 almost count those in Ontario on your hands. It is possible,
18 as it is possible for the surgeon or the radiologist who works
19 only in this way, and only on the type of service to make about
20 that amount.

21 MR. MAJOR: How many patients could a psychiatrist
22 reasonably handle a day? Are there any statistics on this?
23 It seems to me and I am not sure in which organizations
24 presentation to the Royal Commission, but in the back of my
25 mind it keeps going around that generally speaking a psychiatrist



11 in that way -- does this mean back to your mind?
12 That would be your something like the organization a year
13 and over 2,000 psychiatric patients and so on. It also
14 involves a certain number of hospital visits, office calls or
15 routine basis. It was estimated on cost per service in
16 separately along this type of field work being somewhere from
17 \$10.00 to \$15.00 a treatment and then would bring approximately
18 \$40,000 a year income for the psychiatrist in private practice.
19 DR. CHAIKIN: There are psychiatrists who are
20 making this. They are the old experimental psychiatrists who also
21 have to maintain, also, that most of these psychiatrists are
22 on the staffs of general hospitals. They would have public
23 service. They have two patients a week. You may have
24 to give lecture classes. You may have to sit on two hospital
25 committees. It is a very successful psychiatrist who is
26 involved in the working in the night. You could
27 almost count these in terms of your hands. It is possible
28 as it is possible for the average or the psychiatrist who works
29 only in this way, not only on the type of service it takes about
30 that amount.

31 MR. MAJOR: How many patients could a psychiatrist
32 reasonably handle a day? How many are available on shift?
33 It seems to me that I am not sure in which organization
34 mentioned in the Royal Commission, but in the book of
35 what is being done about mental health, especially regarding a psychiatrist



1 had to earn a fairly large fee per treatment because they could
2 only handle eight or nine cases a day.

3 DR. CHALKE: That is psychoanalysts we were
4 talking about who could handle eight or nine, but it is the
5 same eight or nine day in and day out. In general a man working
6 half time in his office in the evening, generally, has to
7 allow an hour per patient because it takes an hour to have a
8 proper consultation and report back to the referring physician.
9 Psychotherapy is generally based on one-half hour or hour
10 schedules. These psyches have a schedule that is set up that
11 way. You have to give a patient a fixed amount of time because
12 it is a continuing process. In an afternoon a psychiatrist
13 might see one consultation and two patients an hour psycho-
14 therapy and three patients he was checking on, checking on
15 their progress, how they were getting along and giving them
16 some advice as to what to do next. This might be an afternoon
17 practice for a psychiatrist.

18 MR. MAJOR: This must be a very busy and wearing
19 mentally job for the psychiatrist. I would say it is hard
20 work in quotes. He couldn't really do a job and handle more
21 patients than seven or eight a day.

22 DR. CHALKE: Most practitioners do a lot more
23 than this. Lots of psychiatrists, people working in Ontario
24 work many more hours than this at things related to their
25 profession, their teaching activities, committee work,



1 had to leave a fairly large gap in treatment because they could
2 only handle eight or nine cases a day.
3 DR. CHALKER: That is psychoanalysts we were
4 talking about who could handle eight or nine, but it is the
5 same eight or nine day in and day out. In general a man working
6 half time in his office in the evening, generally, has to
7 allow an hour per patient because it takes an hour to have a
8 proper consultation and report back to the referring physician.
9 Psychotherapy is generally based on a half hour or hour
10 sessions. These patients have a session that is set up first
11 with you. You have to give a patient a fixed amount of time because
12 it is a continuing process. In an afternoon a psychiatrist
13 might see one consultation and two patients an hour psycho-
14 therapy and three patients he was checking on, checking on
15 some progress. Now they were getting along and giving them
16 some advice as to what to do next. This might be an afternoon
17 practice for a psychiatrist.
18 MR. MALOR: This must be a very busy and wearing
19 mentally job for the psychiatrist. I would say it is hard
20 work in quotes. He couldn't really do a job and handle more
21 patients than seven or eight a day.
22 DR. CHALKER: Most practitioners do a lot more
23 than that. Lots of psychiatrists people working in hospitals
24 work much more hours than this of course related to their
25 position, their research activities, committee work,



1 Association work, their meetings, reading keeping up with
2 Journals. To handle psychotherapy more than seven hours a day
3 is a very exhausting procedure.

4 THE CHAIRMAN: Mr. Major, may I have some help
5 in understanding this point. I am not sure I understand what
6 you are driving at by all these questions.

7 MR. MAJOR: I am driving at the point that under
8 present circumstances and with the event of gradual pulling
9 back into private practice that \$12,000. a year is not sufficient
10 money.

11 THE CHAIRMAN: That is their claim and it isn't
12 our case here to argue it with them. I think it is up to us
13 to try to find that out. Have you any further questions?

14 DR. CHALKE: May I point out, Mr. Chairman,
15 in regard to that amount, the patient, every patient is being
16 analyzed and is not in psychotherapy for an hour a day. You
17 have acute patients in the Ontario Hospital. You don't see
18 them all for an hour a day with psychiatrists at all. Treatment
19 there is very often medication. It is nursing care. It is
20 occupational therapy and the psychiatrist is attending them as
21 he would attend a case of diabetes in a hospital. He doesn't
22 do an hour psychotherapy with all the patients that are under
23 his care.

24 THE CHAIRMAN: Any further questions?

25 DR. GALLOWAY: The thing I would like to have



1.

2.

3.

4. THE CHAIRMAN: Mr. Major, may I have some help

5. in understanding this question? I am not sure I understand what

6. you are driving at by all these questions.

7. MR. MAJOR: I am driving at the point that under

8. present circumstances and with the amount of Government

9.

10.

11. THE CHAIRMAN: That is their claim and it isn't

12. our case here to argue it with them. I think it is up to us

13. to try to find that out. Have you any further questions?

14. DR. CHAIKIN: May I point out, Mr. Chairman,

15. in

16.

17. have acute patients in the Ontario Hospital. You don't see

18.

19.

20.

21.

22.

23.

24. THE CHAIRMAN: Any further questions?

25. DR. GALLOWAY: The thing I would like to have



1 clarified once more, you stated something I don't really think
2 you meant, that you would be happy to be paid only for those
3 cases that were professionally referred. I am thinking of the
4 group of people, if not a large group, they are people with
5 acute emotional disturbances, people brought under your care
6 either through the Courts or through the Police and surely
7 these should be the responsibility of the insuring agency even
8 though they haven't been referred.

9 DR. CHALKE: Initially they should be seen. Dr.
10 Graham might have the complete answer for this from the forensic
11 point of view, but if somebody is in a police station and the
12 police surgeon says take that man off to a psychiatrist and
13 they take them to the emergency department of the Hamilton
14 General Hospital and a resident physician sees the psychiatric
15 emergency -- in other words they don't always need the psychia-
16 trist. It is the first physician to see someone in an acute
17 psychiatric stage. I think the same problem will arise, if you
18 are talking about psychiatric emergencies what is going to
19 happen to the person who is run down in the street and the
20 orthopedic surgeon is the first man to see him. He has a broken leg
21 and the orthopedic surgeon is the first person to see him.
22 The referral idea is complicated.

23 THE CHAIRMAN: Any further questions? Do you
24 have any further statements?

25 DR. CHALKE: I don't think so.



1
2
3
4 group of people, if not a large group, they are people with
5 acute emotional disturbances, people brought under your care
6
7
8 though they haven't been referred.
9
10 DR. CHAIKIN: Initially they should be seen. Dr.
11 Graham might have the complete answer for this from the forensic
12 point of view, but if somebody is in a police station and the
13 police surgeon says take that man off to a psychiatrist and
14 they take them to the emergency department of the Hamilton
15 General Hospital and a resident physician sees the psychiatric
16 emergency -- in other words they don't always need the psychia-
17 trist. It is the first physician to see someone in an acute
18 psychiatric stage. I think the same problem will arise if you
19 are talking about psychiatric emergencies what is going to
20 happen to the person who is run down in the street and the
21 and the orthopedic surgeon is the first person to see him.
22 The referral idea is complicated.
23
24 THE CHAIRMAN: Any further questions? Do you
25
26 DR. CHAIKIN: I don't think so.



1 THE CHAIRMAN: It has been very helpful. Is
2 anyone here for the Nursing Homes.

3
4 BRIEF OF ASSOCIATED NURSING HOMES INCORPORATED

5 ONTARIO

6 Appearances: Mr. James E. Fisher,
7 Rev. E. Gill,
8 Mr. George Newbolt,
9 Mrs. Gladys Lauchin.

10 THE CHAIRMAN: From what I observed I gather
11 you have had an opportunity to read the general statement.
12 Would the spokesman for your delegation please identify himself,
13 and if you wish introduce other members of the panel.

14 REVEREND GILL: It is my privilege to speak for
15 the delegation. My name is E. Gill, General Secretary of the
16 Association. This gentleman on my right is Mr. James Fisher
17 the President of the Association and on my left the Vice-
18 President, Mr. George Newbolt, and Mrs. Gladys Lauchin. What
19 is your position? Gladys has been with us in this Association
20 from its beginning in 1959.

21 THE CHAIRMAN: I am sorry we didn't get the
22 lady's last name.

23 REVEREND GILL: Lauchin, L-a-u-c-h-i-n.

24 THE CHAIRMAN: Do you wish to proceed then, sir?

25 REVEREND GILL: Yes, sir. We consider it a



THE CHAIRMAN: It has been very helpful. Is

STATE OF ASSOCIATION WITH A GROUP OF MEMBERS

ONTARIO

Appearances: Mr. James E. Fisher,
Rev. J. H. Gill,
Mr. George Jacoby,
Mrs. Gladys Lanchin.

THE CHAIRMAN: From what I observed I gather

you have had an opportunity to read the general statement.

and if you wish introduce other members of the panel.

REVEREND GILL: It is my privilege to speak for

the delegation. My name is R. Gill, General Secretary of the

the President of the Association and on my left the Vice-

from its beginning in 1959.

THE CHAIRMAN: I am sorry we didn't get the

lady's last name.

THE CHAIRMAN: Do you wish to proceed then, sir?

REVEREND GILL: Yes, sir. We consider it a



1 privilege to be here today.

2 THE CHAIRMAN: May I interrupt you. Unless you
3 feel more comfortable please feel free to remain seated.

4 REVEREND GILL: Thank you very much. We are happy
5 to have this privilege of discussing these matters with you
6 gentlemen and the ladies today because we as administrators of
7 nursing homes across the Province of Ontario have the health
8 care of several thousand aged people in our care. We are
9 very conscious of the arrangements that are made and the
10 loopholes that there are in the health care of the aged. Many
11 of these aged are indigent, but many are hard working people
12 during their lives and with the changing economic situation
13 from year to year they find that their savings are inadequate
14 to meet the demands upon them. They find it very difficult,
15 many of them to pay very reasonable charges for nursing home
16 care that they are asked to pay. Some, as I have said have
17 savings, and so on, but these are inadequate to meet these
18 charges. They are loathe to become charges upon the municipal-
19 ity from which they come, so here are various problems we are
20 faced with.

21 We feel the Government has to be commended, as
22 set forth in our submission to you, the Government has to be
23 commended for its concern for the health care of the people
24 of Ontario and the health care of the aged is a particular
25 responsibility for these people have rendered very great service



privilege to be here today.

THE CHAIRMAN: May I interrupt you. Unless you

feel more comfortable, please feel free to remain seated.

REVEREND GILL: Thank you very much. We are happy

to have the presence of the members of the board with us

and we believe that because we are representatives of

various boards across the Province of Ontario we are in a

care of several thousand aged people in our care. We are

very conscious of the responsibilities that are made for

us and we believe that there is a great deal of work to be

done and we believe that we are in a position to do it.

We believe that we are in a position to do it with the

resources that we have and we believe that we are in a

position to do it with the resources that we have and we

believe that we are in a position to do it with the

resources that we have and we believe that we are in a

position to do it with the resources that we have and we

believe that we are in a position to do it with the

resources that we have and we believe that we are in a

position to do it with.

We feel the Government has to be commended, as

set forth in our submission to you, the Government has to be

commended for the concern for the welfare of the people

of Ontario and the health care of the people is a

responsibility that the Government has to take very seriously.



1 to the Province or to the Country and at the end are unable to
2 manage for themselves as well as they had hoped and expected to
3 be able to do. We feel that the legislation which set up the
4 Ontario Hospital Service Commission some five years ago was
5 a very commendable piece of legislation and has greatly served
6 the population as a whole. We feel with the mechanics of the
7 present legislation there is very little promise that it will
8 meet the needs of the population as a whole anything near as
9 well as Hospital Services Commission does, which is pretty
10 close to 100% coverage, I think of late.

11 We feel that, of course, the financial basis
12 for this insurance is somewhat disappointing. We feel that
13 Saskatchewan with 100% coverage is a very much happier
14 arrangement than Alberta with a very small percentage, but this
15 isn't our primary concern. We feel that there are those far
16 better able than we to discuss the financing of it. Our
17 concern is for the inadequate coverage that is likely to occur ,
18 not only from the point of view of not enough people being
19 protected health-wise by the plan that is being considered,
20 but that the plan itself is not wide enough. It is another
21 piece of piece-meal legislation. Now, it may be that members
22 of this Enquiry will feel these are not appropriate remarks,
23 but we feel they need to be made somewhere, sir.

24 Dental care is just as essential to good health
25 as the care of a physician or a surgeon and it is just as

Dental care is just as essential to good health as the care of a person's teeth. It is just as important to have a good dental plan as it is to have a good health plan. We feel that the legislation which set up the Ontario Hospital Services Commission some five years ago was a very commendable piece of legislation and has greatly helped to meet the needs of the population as a whole. It will be a long time before we have a population as a whole, in that with the passage of the present legislation there is very little doubt that it will meet the needs of the population as a whole anything near as well as hospital services have done in the past. When it comes close to 100% coverage, I think of late.

We feel that, of course, the financial basis of this insurance is a very important one. We feel that Saskatchewan with 100% coverage is a very much happier place than this province is at present. We feel that it isn't our primary concern. We feel that there are those far better able than we to discuss the financing of it. Our concern is that the insurance system should be able to provide for the health care of all people being protected health-wise by the plan that is being considered, but that the plan itself is not wide enough. It is another piece of legislation that is being considered, and it may be that some of this legislation will be passed and will be a very important one. We feel that it will be a very important one, and we feel that it will be a very important one.



1 universal a care, a need as the care of the physician. In our
2 nursing homes we have people from 50 to 100 years of age
3 gumming their way unhappily to an earlier death than would
4 otherwise be necessary because they are unable to afford or
5 their families are unable to afford or the Municipality refuses
6 to afford the dental care that they desperately need. This
7 isn't just true of aged people who suffer so significantly in
8 this respect. We know young people also whose mouth health is
9 very much less than it should be because dental care is beyond
10 their means and the means of their parents to provide for them.
11 We have in our homes elderly people as I say, from 50 years of
12 age and up, who would be singularly benefited by physiotherapy
13 or physical therapy as it is called in your Act, but it is
14 expensive and so this kind of care is not received because
15 Municipalities will not pay for it. The individual has no
16 money. The family has no money. The doctors who care for him
17 generally say well, it would certainly benefit him but who is
18 going to give up food and things that are necessary. We feel,
19 sir, that this legislation would serve the people of Ontario
20 manifestly better if it was broader in its application than
21 just to physician and surgeon services.

22 We feel also that nursing services in nursing
23 homes should be provided in many cases under some such financial
24 arrangement as this, as nursing services are provided by Ontario
25 Hospital Services Insurance in the hospitals, but not in



Hospital Services Insurance in the hospitals, but not in

agreement as this, as nursing services are provided by Ontario
nurses should be provided in the same manner as in the hospitals.

We feel also that nursing services in hospitals

just to physician and surgeon services.

manifestly better if it was broader in its application than

and, that this legislation would serve the people of Ontario

to give up 1000 and 1500 and the necessary, we feel

Generally say well, it would certainly benefit him but who is

money. The family has no money. The doctors who care for him

Municipalities will not pay for it. The individual has no

expensive and so this kind of care is not received because

of physical therapy as it is called in very few, but it is

and we would be extremely benefited by physiotherapy

as there is no longer extremely expensive, I will from 50 years of

their needs and the needs of their families to provide for them

very much later than it would be in a general hospital and beyond

this respect, we know that people who would benefit in

that kind of care people who suffer as significantly as

to attend the mental care that they desperately need. This

that the people who would be affected by the hospital's services

to be necessary because they are unable to attend in

because they are unable to attend in the hospital and

because we have people from 50 to 100 years of age

and we need a kind of the hospital, in our



1 nursing homes, but we do go along with this Act in the belief
2 that the nursing services should be included in the responsib-
3 ility for the Hospital Services Commission rather than in this
4 type of legislation until such time, if the time ever comes,
5 sir, when all the health legislation of the Province is under
6 one package, it is properly and thoroughly integrated and
7 administered and then the emergent problems with regard to
8 health, no matter what they are, will be handled from one
9 source and paid for in some one manner. We will be pleased
10 to answer to the best of our ability the question that the
11 members of this Enquiry will ask of us. Some of us operate
12 nursing homes that are partially or completely approved for
13 payment under the Hospital Services Commission. Others operate
14 homes in areas which have no need of nursing homes to be
15 approved in that there are sufficient chronic beds in general
16 hospitals or chronic hospitals to meet the needs of those
17 communities.

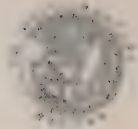
18 THE CHAIRMAN: Thank you. Do you have some
19 questions Mrs. Aylen.

20 MRS. AYLEN: How many homes would be in your
21 Association.

22 REVEREND GILL: Approximately 100.

23 MRS. AYLEN: They are all registered, I would
24 imagine.

25 REVEREND GILL: Licenced.



1. ...
2. ...
3. ...
4. ...
5. ...
6. ...
7. ...
8. ...
9. ...
10. ...
11. ...
12. ...
13. ...
14. ...
15. ...
16. ...
17. ...
18. ...
19. ...
20. ...
21. ...
22. ...
23. ...
24. ...
25. ...
26. ...
27. ...
28. ...
29. ...
30. ...
31. ...
32. ...
33. ...
34. ...
35. ...
36. ...
37. ...
38. ...
39. ...
40. ...
41. ...
42. ...
43. ...
44. ...
45. ...
46. ...
47. ...
48. ...
49. ...
50. ...
51. ...
52. ...
53. ...
54. ...
55. ...
56. ...
57. ...
58. ...
59. ...
60. ...
61. ...
62. ...
63. ...
64. ...
65. ...
66. ...
67. ...
68. ...
69. ...
70. ...
71. ...
72. ...
73. ...
74. ...
75. ...
76. ...
77. ...
78. ...
79. ...
80. ...
81. ...
82. ...
83. ...
84. ...
85. ...
86. ...
87. ...
88. ...
89. ...
90. ...
91. ...
92. ...
93. ...
94. ...
95. ...
96. ...
97. ...
98. ...
99. ...
100. ...



1 MRS. AYLEN: Licenced.

2 REVEREND GILL: Yes, licenced.

3 MRS. AYLEN: Are some of these religious
4 institutions or community institutions.

5 REVEREND GILL: I don't think we have any member
6 homes that are distinctly religious in that they are owned and
7 operated by religious organizations. My own is a home where
8 religion is fairly prominent, but still it is a privately owned
9 institution and not owned by any church.

10 MRS. AYLEN: What would be the average number of
11 beds in these homes?

12 REVEREND GILL: We think that the average would
13 be about 20 beds per home.

14 MRS. AYLEN: That would be anywhere from ten up?

15 REVEREND GILL: From 5 to 50 or 60. I think 60,
16 5 to 60.

17 MRS. AYLEN: I was interested reading the brief
18 at number 3 on page 1:

19 "The Medical Services Insurance Act as presented
20 by the Government, and in its present form, is,
21 apparently an attempt to recognize a presumed
22 need of the population of Ontario. There is no
23 evidence that this need is general throughout the
24 Province."

25 I was very much surprised to read that. Would all your patients



MR. AYLIN: (Continued)

REVEREND GILL: Yes, indeed.

MRS. AYLIN: Are some of these religious

institutions or community institutions.

REVEREND GILL: I don't think we have any number

of houses that are distinctly religious in that they are owned and

operated by religious organizations. My own is a home where

religion is fairly prominent, but still it is a privately owned

institution and not owned by any church.

MR. AYLIN: That would be the average number of

100 in these homes?

REVEREND GILL: We think that the average would

be about 100 beds per home.

MRS. AYLIN: That would be anywhere from ten up?

REVEREND GILL: From 5 to 50 or 60. I think 60,

10 or 20.

MRS. AYLIN: I was interested reading the brief

at number 3 on page 12

"The Medical Services Insurance Act as presented

by the Government, and in its present form, is,

apparently an attempt to introduce a program

need of the population of Ontario. There is no

evidence that this need is general throughout the

Province."

I am very much surprised to read that. Would all four patients



1 be given adequate medical care.

2 REVEREND GILL: I would say yes. I don't know of any
3 case where a well run nursing home doesn't see a patient gets
4 adequate medical care.

5 MRS. AYLEN: Who pays for that.

6 REVEREND GILL: There would be a number of
7 different sources. The patient in many cases pays for his
8 or her own family, and then the Municipality--- no, where the
9 Municipality pays for the patient's care or a proportion of it
10 the patient usually carries what is called a Medical Welfare
11 card providing for the medical welfare plan of the Province of
12 Ontario.

13 MRS. AYLEN: That is a subsidized service.

14 REVEREND GILL: Yes, quite so.

15 MRS. AYLEN: Going down that page you state that
16 people getting medical care -- before this and
17 so on, indigents and the aged.

18 How would you classify them?

19

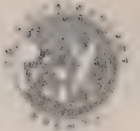
20

21

22 Would this be run by the Welfare Department related to the
23 service.

24 REVEREND GILL: Almost, I should think.

25



1 be given adequate medical care.

2 REVEREND GILL: I would say yes. I don't know of any

3 cases where I will not receive from the Government any

4 adequate medical care.

5 MRS. AYLMER: Who pays for that.

6 REVEREND GILL: There would be a number of

7 different sources. The patient himself pays for his

8 out-of-pocket expenses, and the Government pays for the

9 hospitalization for the patient's care as a proportion of it

10 the patient himself pays what is called a medical welfare

11 fund providing for the medical welfare plan of the province of

12 Ontario.

13 MRS. AYLMER: That is a subsidized service.

14 REVEREND GILL: Yes, it is.

15 MRS. AYLMER: Going down that page you state that

16 people getting medical care -- before this and

17 so on, indigents and the aged.

18 How would you classify them?

19 Would this be run by the Welfare Department related to the

20 REVEREND GILL: Almost, I should think.



1 MRS. AYLEN: It would not be classified as
2 nursing homes?

3 REVEREND GILL: No.

4 MRS. AYLEN: Then you also say -- the pages
5 aren't numbered, but I numbered them myself, so number 3,
6 under item 7 you say that it is difficult to understand how
7 the Medical Service Insurance Act offers any more protection
8 to residents of Ontario than the protection already available
9 through insurance companies. Do you find that most of these
10 people who are in your homes are covered through insurance?
11 Are they eligible for insurance?

12 REVEREND GILL: Not most of our homes. That
13 statement here is that most of the residents of Ontario would
14 find that there is insurance available to them at the present
15 time.

16 MRS. AYLEN: I thought you were dealing with
17 people in your homes.

18 REVEREND GILL: No. Our feeling is that they
19 need dental care and physiotherapy and many of them need
20 assistance with the payment of nursing care services.

21 MRS. AYLEN: Is there any voluntary contribution
22 to any of these homes? No organization that will come in and
23 help in any of this occupational therapy or any other things?

24 REVEREND GILL: Very slight -- to a very slight
25 degree. This year we have had the beginning of assistance in



MRS. ALLEN: It would not be classified as

noting names

REVEREND GILL: No.

MRS. ALLEN: Then you also say -- the pages

aren't numbered but I understand them myself, so number 3.

under item 7 you say that it is difficult to understand now

the Medical Service Department and others say more protection

to protection of patients and the protection already available

through hospital personnel. Do you think that sort of course

people are not in your homes are not enough immediately

Are they eligible for insurance?

REVEREND GILL: Not most of our homes. That

statement says in fact most of the residents of Ontario would

find that their insurance available to them in the present

state.

MRS. ALLEN: I thought you were dealing with

people in your homes.

REVEREND GILL: No. Our feeling is that they

would be able to get and understand and many of them need

assistance with the payment of nursing home services.

MRS. ALLEN: Is there any voluntary contribution

in any of these homes? An organization that will come in and

help in any of these occupational therapy or any other kind of

REVEREND GILL: Very slight -- to a very slight

degree. This year we have had the beginning of assistance in



1 our own home from the Alexander Hospital Auxilliary. You
2 can speak on this do you not think Mr. Fisher.

3 MR. FISHER: Because we are a private enterprise
4 we are expected, naturally, to pay for any service received
5 and we find this is a little costly for us to provide for
6 people who are unable to pay for them; for us to provide.

7 MRS. AYLEN: Then you say that this Bill does
8 not provide for nursing care, operating nursing care. Don't
9 you have to give nursing care? Isn't that part of the treatment?

10 REVEREND GILL: That is true. It is also true
11 in the case of the hospital. The Commission guarantees them
12 \$20.00, \$30.00 a day to cover all these things.

13 MRS. AYLEN: If your homes are under the O.H.S.C.
14 they must provide nursing care.

15 REVEREND GILL: We do have to provide nursing
16 care, of course.

17 MRS. AYLEN: That is covered by the O.H.S.C.

18 REVEREND GILL: About \$6.00 a day.

19 MR. FISHER: We receive a rate of \$6.50 per day.
20 If I might just enlarge a little on the therapy end of it.
21 Therapy treatments are not covered in nursing homes; covered
22 by the Ontario Hospital Services Commission and this is just
23 why I would mention this: When Mr. Gill states that nursing
24 care be paid for, this is one of the types of nursing care that
25 he is relating to.



1 my own name from the Alexander Hospital Authority. You

2 can speak on this do you not think Mr. Fisher.

3 MR. FISHER: Because we are a private enterprise

4 we are expected, naturally, to pay for any service received

5 and we find this is a little costly for us to provide for

6 people who are unable to pay for them; for us to provide.

7 MR. ALLEN: Then you say that this Bill does

8 not provide for nursing care, operating nursing care, dental

9 you have to give nursing care, dental that part of the treatment

10 REVEREND GILL: That is true. It is also true

11 in the case of the hospital, the Commission has been

12 \$20.00, \$30.00 a day to cover all these things.

13 MRS. ALLEN: If your figures are under the O.H.S.C.

14 they must provide nursing care.

15 REVEREND GILL: We do have to provide nursing

16 care, of course.

17 MRS. ALLEN: That is covered by the O.H.S.C.

18 REVEREND GILL: About \$6.00 a day.

19 MR. FISHER: We receive a rate of \$6.50 per day.

20 If I might just say a little on the therapy end of it.

21 Therapy treatments are not covered in nursing homes; covered

22 by the Ontario Hospital Services Commission and this is just

23 why I would mention this: When Mr. Gill states that nursing

24 care is paid for, this is one of the types of nursing care that

25 he is relating to.



1 REVEREND GILL: It should be mentioned, Mrs.
2 Aylen, that of the 384 licenced nursing homes in Ontario, only
3 about 50 have a part of their -- only some of their beds
4 approved for payment from the Commission so that this is a
5 relatively small proportion.

6 MRS. AYLEN: Yes, I quite understand that.
7 Thank you Mr. Chairman, I think that is all I have to ask.

8 THE CHAIRMAN: Why is it that the other ones are
9 not approved?

10 REVEREND GILL: Because in their communities
11 sir the Commission considers there are enough publicly provided
12 chronic care beds in the general hospital, or a chronic care
13 hospital. It has no reference to the quality of the nursing
14 homes in the community.

15 THE CHAIRMAN: Mr. Caswell?

16 MR. CASWELL: There is very little I want to
17 ask except one question for clarification. I am under the
18 impression that nursing homes in the Province of Ontario are
19 operated largely as a private enterprise?

20 REVEREND GILL: Yes.

21 MR. CASWELL: And I assume that they are operated
22 as a profit enterprise. They are operated as any other business,
23 to make a profit. Therefore, I do not see why they are
24 charitable or anything, a profit-making business.

25 REVEREND GILL: That is the effort sir.



REVEREND GILL: It would be wonderful, Mrs.

AYLIN, that of the 384 licensed nursing homes in Ontario, only

about 50 have a part of their — only some of their beds

approved for payment from the Commission so that this is a

relatively small proportion.

MRS. AYLIN: Yes, I quite understand that.

Thank you Mr. Chairman. I think that is all I have to say.

THE CHAIRMAN: Why is it that the other ones are

not approved?

REVEREND GILL: Because in their communities

the Commission considers there are enough publicly provided

chronic care beds in the general hospital, or a chronic care

hospital. It has no reference to the quality of the nursing

homes in the community.

THE CHAIRMAN: Mr. Caswell?

MR. CASWELL: There is very little I want to

ask except one question for clarification. I am under the

impression that nursing homes in the Province of Ontario are

operated largely as a private enterprise?

REVEREND GILL: Yes.

MR. CASWELL: And I assume that they are operated

as a profit enterprise. They are operated as any other business

to make a profit. Therefore, I do not see why they are

considered as anything, a profit-making business.

REVEREND GILL: That is the effort sir.



1 MR. CASWELL: Your brief is quite clear, as
2 far as I am concerned. You are suggesting a more comprehensive
3 Bill than the medical plan which has been presented. I do
4 not see any question to ask on that. We have had several
5 briefs submitted to us that suggested that there should be a
6 more comprehensive plan, and as far as I am concerned, speaking
7 personally, certainly your brief deserves some consideration on
8 merit, and the fact that you are interested in other services
9 but it seems to me to be a brief presented by a profit business
10 enterprise.

11 REVEREND GILL: Yes.

12 MR. CASWELL: I think it is quite clear that all
13 you are asking for is the plan to be more liberal and more
14 generous.

15 MR. FISHER: That is right.

16 THE CHAIRMAN: Dr. Hamilton?

17 DR. HAMILTON: Thank you. Mr. Gill there is
18 one statement in paragraph 7 I am not quite sure I understand
19 what it means. There is reason to believe that people who
20 now own insurance of this nature would not be reached by the
21 provisions of the Medical Services Insurance Act. What
22 people would not be reached?

23 REVEREND GILL: The people who did the research
24 and prepared the brief, or the Submission felt that the people
25 who are not now buying insurance were not likely to buy



1 MR. GARDNER: Your brief is quite clear, as
2 far as I am concerned. You are suggesting a more comprehensive
3 Bill than the original Bill which has been presented. I do
4 not see any question to ask on that. We have had several
5 Bills submitted to us that suggested that there should be a
6 more comprehensive Bill, and as far as I am concerned, speaking
7 personally, certainly your Bill deserves more consideration on
8 merits, and the fact that you are interested in other services
9 but it seems to me to be a Bill presented in a public business
10 enterprise.
11
12 MR. GARDNER: I think it is quite clear that all
13 you are asking for is the plan to be more liberal and more
14 generous.
15
16 MR. FISHER: That is right.
17
18 THE CHAIRMAN: Dr. Hamilton?
19 DR. HAMILTON: Thank you, Mr. Gill there is
20 one statement in paragraph 7 I do not quite agree I understand
21 what it means. There is reason to believe that people who
22 now are interested in this matter would not be reached by the
23 provisions of the Medical Services Insurance Act. What
24 people would not be reached?
25
26 THE CHAIRMAN: The people who did the research
27 and prepared the brief, or the Sub-committee that the people
28 are not having reached with this Bill, is that



1 insurance because the Government said you should. That there
2 would not be a large extension of the insurance coverage in
3 the Province because the Government encourages people, unless
4 this encouragement took a monetary form far larger than had
5 been likely at the present time.

6 MR. NAYLOR: You mentioned the Ontario Hospital
7 Plan had been very successful and covers almost 100%. It is
8 not compulsory except for groups of 15 or more. The others
9 have to buy it voluntarily. I think that it has been success-
10 ful.

11 REVEREND GILL: You have mentioned sir a
12 compulsory aspect. A lot of people are included in this 15
13 or more, an awful lot of people. Then the monetary aspect
14 covers the rest. \$2.10 a month for an individual, or \$4.10
15 a month for a family is a very small cost by comparison with
16 the anticipated cost of this plan which provides, as we suggest,
17 too narrow a group of services.

18 MR. MAJOR: What you are suggesting sir is that
19 if the Government subsidizes everybody in the Province this
20 might be a success.

21 REVEREND GILL: Yes, that is correct.

22 THE CHAIRMAN: We should follow our regular
23 procedure here. Dr. Hamilton do you have any other questions
24 you wish to ask?

25 DR. HAMILTON: I have no further questions.

[illegible]

1. The following information was obtained from the records of the
2. Bureau of the Census, Washington, D. C., for the year 1954:
3. The total population of the United States was 166,000,000.
4. The total population of the State of California was 15,000,000.
5. The total population of the County of Los Angeles was 4,000,000.
6. The total population of the City of Los Angeles was 2,000,000.
7. The total population of the City of Los Angeles was 2,000,000.

REVEREND GILL: You have mentioned Sir a

17 too narrow a group of services.
18 the anticipated work of this field division, as we suggest
19 a grant for a family is a very small cost of cooperation with
20 courts and staff, \$2.14 a month for an individual, or \$4.10
21 on average, an entire lot of families. Then the community support
22 emergency support. A lot of people are included in this in

MR. MAJOR: What you are suggesting sir is that

might be a success.

STEWART GILL: Yes, that is correct.

THE CHAIRMAN: We should follow our regular

you wish to ask?

DR. HAMILTON: I have no further questions.



1 THE CHAIRMAN: Mr. Major?

2 MR. MAJOR: I have one question Reverend Gill I
3 wonder if you could help me with. We have had several organ-
4 izations intimate to us that there is quite a difference
5 between the means test for food and shelter and a means test
6 for medical care. This difference is very peculiar and
7 particular. Everybody has agreed so far that has appeared
8 before us on this question that a means test for medical care
9 is degrading. It lowers the dignity. There is a tremendous
10 loss of pride to the individual concerned. They do not maintain
11 this degradation and lowering of dignity when the means test
12 is applied to food and shelter. Can you help us with this
13 particular question?

14 REVEREND GILL: Possibly a little sir. In my
15 own experience as a Minister, a pastor I know that people who
16 are hungry suffer a very great loss of pride. People who are
17 in really desperate circumstances will accept help but the
18 need for dental care or medical care has to become very acute
19 before they will admit that they are unable to meet it them-
20 selves and it won't get that acute so as to have them go in
21 and apply for Government assistance in getting health insurance.
22 This is the opinion of our group.

23 MR. MAJOR: That is the best explanation we have
24 had sir. In other words, a sore stomach that is full takes
25 a great deal more motivation to degrade itself than a sore



THE CHAIRMAN: Mr. Major?

MR. MAJOR: I have one question Reverend Gill I

wonder if you would help me with. We have had several ques-

tions introduced to us that there is quite a difference

between the means test for food and shelter and a means test

for medical care. This difference is very peculiar and

peculiar. Everybody has agreed so far that has appeared

before us on this question that a means test for medical care

is necessary. It follows the ability. There is a tremendous

loss of pride to the individual concerned. They do not maintain

this condition and looking of dignity when the means test

is applied to food and shelter. Can you help us with this

particular question?

REVEREND GILL: Possibly a little sir. In my

own experience as a minister, a pastor I know that people who

are hungry suffer a very great loss of pride. People who are

in really desperate circumstances will accept help but the

need for social care or medical care has to become very acute

before they will admit that they are unable to meet it them-

selves and it won't get that acute to us to have them go in

and apply for Government assistance in getting health insurance.

This is the opinion of our group.

MR. MAJOR: That is the best explanation we have

and sir. In other words, a poor stomach that is full takes

a great deal more motivation to regard itself than a



1 stomach that is empty?

2 REVEREND GILL: That is correct sir.

3 MR. MAJOR: Now on page 3, just for clarification,
4 in paragraph 6 you are not intimating, of course, that the
5 Saskatchewan Medical Care Plan covered all nurses and dentists,
6 and so on and so forth?

7 REVEREND GILL: I don't think so sir.

8 MR. MAJOR: It only covers medical care. In
9 fact, it does not cover all medical care. Is that correct?
10 Are you correct in this \$12.00 per family per year? I don't
11 know whether you are correct that that is what is being charged.

12 MR. NAYLOR: That is not what it is, because
13 there is a large subsidy from taxes in addition going into the
14 cost of the plan.

15 REVEREND GILL: I would think that this is a
16 very large factor in the popularity of the plan, when it
17 reaches so many people.

18 MR. MAJOR: Its popularity is based on the fact
19 everybody must belong. I don't know what the penalty is if
20 you don't join but everybody must belong but the point I want
21 to bring forth is, I don't want any confusion between your
22 Submission and this Enquiry that Saskatchewan have a comprehen-
23 sive Health Service. They don't even have a full medical care
24 service. That is physician's care service, and get away from
25 that medical. People think that covers everything. It doesn't



1 REVEREND GILL: That is correct sir.
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25



1 have full physician care service. That is the point I want to
2 bring out.

3 REVEREND GILL: I wish that I were as familiar with
4 the situation in Alberta and in Saskatchewan and in England
5 as some of you I am sure are.

6 MR. CASWELL: Mr. Chairman, it should be pointed
7 out that the grant to the Saskatchewan Medical Care is not from
8 taxes. It is from the oil subsidy. There is a very substantial
9 grant being made from the oil subsidy the Government collects
10 to the medical care. Saskatchewan ran into trouble. This is
11 the way they are pacifying the Government.

12 MR. MAJOR: This is a fine application of a
13 practical basis of the economic theory of rent.

14 THE CHAIRMAN: Does that complete your questioning?

15 MR. MAJOR: That completes my questioning.

16 THE CHAIRMAN: Mr. Simon?

17 MR. SIMON: My question has been partially
18 answered. I was concerned with the contradiction in the few
19 statements, in 3 and in 9. 3 said there is no need for such
20 care and in 9 they spell out the kind of plan they suggest they
21 could have. I think it has been quite well answered.

22 THE CHAIRMAN: Mr. Naylor?

23 MR. NAYLOR: I want to make one or two comments.
24 They are not exactly questions but I believe there is some
25 inaccuracy in one paragraph of the brief and also in perhaps



1 have that physician come and visit. That is the point I want to

2 make.

3 I want to say I want that I want to have a committee

4 the committee in Alberta and in Saskatchewan and in Manitoba

5 as some of you I am sure are.

6 MR. CASWELL: Mr. Chairman, it should be pointed

7 out that the report of the Saskatchewan Medical Association is not from

8 taxes. It is from the old industry. There is a very substantial

9 grant being made from the old industry and the Government. This is

10 to the medical care. Saskatchewan has no income tax. This is

11 the way they are paying the Government.

12 MR. MAJOR: This is a fine application of a

13 practical basis of the economic theory of rent.

14 THE CHAIRMAN: Does that complete your questioning?

15 MR. MAJOR: That completes my questioning.

16 THE CHAIRMAN: Mr. Simon?

17 MR. SIMON: My question has been partially

18 answered. I was concerned with the contribution in the two

19 statements, in 2 and in 3. I said there is no need for such

20 case and in 3 that would be the kind of thing that they suggest they

21 could have. I think it has been quite well answered.

22 THE CHAIRMAN: Mr. Taylor?

23 MR. TAYLOR: I want to make one or two comments.

24 They are not really questions but I believe there is some

25 discrepancy in our reports of the trial and also in perhaps



1 an impression you may have created by one statement you made.
2 I am referring to paragraph 5. You mention the premiums for
3 the Province of Alberta \$162.00 per family per year. That is
4 not correct. The maximum premium for a family of three or more
5 in Alberta is \$159.00. The maximum premium for a family of
6 two is \$126.00 and I want to emphasize those are maximum
7 premiums. Quite a substantial number of policies are sold at
8 less than those maximum premiums. For example, M.S.I., which
9 is comparable to P.S.I. in Ontario, sells a policy to anybody
10 at the same rate, regardless of age and their rate for a family
11 of three or two is well below the maximum figures I have
12 mentioned.

13 Then you suggest that the Alberta plan has not
14 been successful in that only one of five, eligible for Govern-
15 ment subsidy, has actually taken insurance. I don't know
16 where that information came from but the information I have
17 is quite different. There is a statement made by the Minister
18 of Health, Mr. Ross, which was in the Alberta Press giving the
19 results after the first three months initial enrolment period
20 and he states in this statement that about one million one
21 hundred thousand Albertans, almost 80% of the Province, one
22 million four hundred thousand population, have some form of
23 prepaid medical care insurance. Now this total includes one
24 hundred and fifty thousand persons under policies on which the
25 Government provides a premium subsidy and that is more than



516

1 we expressed you may have created by one statement you made.
2 I am referring to paragraph 5. You mention the premiums for
3 the Province of Alberta \$102.00 per family per year. That is
4 not correct. The maximum premium for a family of three or more
5 in Alberta is \$159.00. The maximum premium for a family of
6 two is \$126.00 and I want to emphasize these are maximum
7 premiums. Quite a substantial number of policies are sold at
8 less than these maximum premiums. For example, M.A.I., which
9 is comparable to B.A.I. in Ontario, sells a policy to anybody
10 at the same rate, regardless of the and family rate for a family
11 of three or less is well below the maximum figures I have
12 mentioned.
13 Then you suggest that the Alberta plan has not
14 been successful in that only one of five, eligible for govern-
15 ment subsidy, has actually taken advantage. I don't know
16 where this information came from but the information I have
17 is quite different. There is a statement made by the Minister
18 of Health, Mr. Hoyt, when he was in the Alberta House giving the
19 results after the first survey which initial enrolment reached
20 and he states in this statement that about one million and
21 one-half thousand Albertans, almost 8% of the Province, are
22 eligible for insured through provincial plans some form of
23 prepaid medical care treatment. Now this total includes one
24 hundred and fifty thousand persons under policies of which the
25 Government provides a premium subsidy and that is more than



1 10% of the population so that is considerably more than one
2 in five.

3 REVEREND GILL: It would seem so.

4 MR. NAYLOR: That is all.

5 DR. BUTT: I just really have one comment. Under
6 this scheme that you seem to wish it extended to, do you really
7 feel that any Government would allow the nursing homes to
8 continue as they do now? They would have control. They are
9 certainly going to put them into a chronic wing of a hospital
10 and let it go at that.

11 REVEREND GILL: I am afraid I did not get the
12 point of your question.

13 DR. BUTT: The point simply means that you are
14 proposing an all-inclusive scheme run by the Government. Do
15 you feel then that they are going to allow small individual
16 enterprises in this field to continue?

17 REVEREND GILL: I don't see why not.

18 DR. BUTT: All right, thank you.

19 MRS. MCARTHUR: Mr. Chairman, might I ask the
20 delegation who is the licencing authority and perhaps I should
21 know this: To what extent are standards set up and required
22 to be maintained in order to be licenced and is it a yearly
23 licence?

24 REVEREND GILL: Yes, it is a yearly licence.
25 It must be renewed by the first or second day of January each



1 100 of the population as there is considerably more than one

2 in five.

3 REVEREND GILL: It would have to.

4 MR. MAYNOR: That is all.

5 DR. BUTT: I have really been very anxious, under

6 this system that you were to have it continued so, the really

7 feel that the Government would allow the existing houses to

8 continue as they are now. They would not demolish. They are

9 certainly going to put in a new wing at a hospital.

10 and let it go at that.

11 REVEREND GILL: I am afraid I did not get the

12 point of your question.

13 DR. BUTT: The point simply means that you are

14 proposing an alternative scheme for the Government. Is

15 your first time that they are going to allow small buildings

16 enterprises in this field to continue?

17 REVEREND GILL: I don't see why not.

18 DR. BUTT: All right, thank you.

19 MRS. MCARTHUR: Mr. Chairman, might I ask the

20 Government whether it is the intention to continue to build

21 new houses? To what extent are standards set up and regulated

22 so as to maintain the quality of the houses and is it a yearly

23 inspection?

24 REVEREND GILL: Yes, it is a yearly licence.

25 It must be renewed by the first of January and by the 1st of January



1 year or it is considered to have lapsed and Welfare payments
2 will not be payable in January or thereafter. The licencing
3 authority is local. That is to say Municipal. The Government
4 of Ontario has set up the model bylaw for municipalities to
5 pass and administer including licencing of all nursing homes
6 within the boundaries of those municipalities. Municipalities
7 must do the inspection, sanitary, fire, safety, and so on, and
8 issue the licence.

9 MR. SIMON: One more question. Who provides
10 medical care for most of your patients? I understand the
11 hospital insurance pays for their bed; some of them. What about
12 doctor bills, who pays for that? Do they carry insurance
13 through private carriers or are they self-sustaining or what,
14 in some of these homes?

15 REVEREND GILL: In most cases they are self-
16 sustaining. I would say not any instance, in our own 30 bed
17 nursing home, is there any insurance paid. I don't know
18 whether that is applicable in the other homes represented
19 here today or not. Do you have any insured people?

20 MR. FISHER: In fourteen years in business, with
21 45 patients I would say that there would not be over 2% that
22 would carry insurance of any kind, as far as medical insurance
23 in my establishment.

24 THE CHAIRMAN: Was the question who does pay
25 for it?



1 year or it is continued by other means and without payment
2 will not be payable in advance of the year. The licensing
3 authority is local. That is to say, the local authority.
4 of Ontario has not yet the right to pay for municipalities to
5 pass and administer by-law licensing of all existing and
6 within the boundaries of those municipalities. Municipalities
7 have to the licensing authority, that is, they have to pay
8 for the licensing.

9 MR. SIMON: One more question. Who provides
10 medical care for most of your patients? I understand the
11 hospital finances pay for their beds, some of them. What about
12 doctor bills, who pays for that? Do they carry insurance
13 through private carriers or are they self-insured or what?
14 in some of these homes?

15 REVEREND GILL: In most cases they are self-
16 insuring. I would say not self-insuring. In our own 30 bed
17 nursing home, it is done by insurance paid. I don't know
18 whether that is typical in the other homes represented
19 here today or not. Do you have any further queries?

20 MR. FISHER: In fourteen years in business, with
21 22 patients I would say that there would not be over 25 that
22 would carry insurance of any kind, or for as medical insurance
23 in my establishment.

24 THE CHAIRMAN: Was the question who does pay



1 MR. SIMON: Who paid for the medical service?

2 MR. FISHER: Windsor Medical, or any other
3 medical service.

4 MR. SIMON: Somebody has to pay the premiums for
5 these people. Who pays the premiums for them. Themselves?

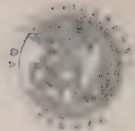
6 MR. FISHER: Themselves.

7 MR. NEWBOLT: I think in most cases nursing
8 home administrators will have very little contact between the
9 patient and the doctor. The doctor and the patient conduct
10 their own financial arrangements between themselves. We are
11 not petitioning here in order to get anything for ourselves
12 as administrators in a monetary way. This is primarily
13 concerned with the, shall we use the word loophole coverage
14 for certain classes of our citizens, medical, dental care,
15 physiotherapy and that sort of thing.

16 MR. SIMON: Do you find that your patients are
17 adequately taken care of medically, as far as they are concerned?

18 MR. NEWBOLT: It is quite conceivable we would
19 not know how they are taken care of.

20 THE CHAIRMAN: Maybe we could clear this up
21 if you would answer another question. Your patients are not
22 indigents. They pay their own way. You give them a service.
23 You charge a fee for their expenses at your home, either the
24 patient himself or his family. Somebody has to pay for his
25 being at the home. Likewise, if he or she is to receive medical



219

MR. SIMON: Who paid for the medical services?

MR. FISHER: Windsor Medical, or any other

medical service.

MR. SIMON: Somebody has to pay the premiums for

these people. Who pays the premiums for them, the insurance?

MR. FISHER: Themselves.

MR. NEWBOLT: I think in most cases nursing

home administrators will have very little contact between the

patients and the doctors. The doctor and the patient would

be in their own hospital separately from the nursing home.

and the nursing home is not really for patients

as administrators in a monetary way. This is primarily

concerned with the fact that the word "hospital" means

for certain classes of patients, medical, mental, etc.

physiology and the fact of being.

MR. SIMON: Do you find that your patients are

not getting the same care of medicine as far as they are concerned?

MR. NEWBOLT: It is quite conceivable we would

not know how they are taken care of.

THE CHAIRMAN: Maybe we could clear this up

if you would answer another question. Your patients are not

indicated that they have been a service.

Do they have a fee for their expenses at your home, either the

patient himself or his family. I would like to see the bill

before we can know. Likewise, if it is or else is to receive medical



1 attention, somebody has to arrange for payment of that and that
2 is not the responsibility of the home.

3 REVEREND GILL: That is correct. It would not
4 be true to say they are not indigent in the technical sense.
5 In many cases -- referring to my own 25 patients at the present
6 time, 12 of them are indigents. That is to say the nursing
7 home is paid approximately \$100.00 a month for their care and
8 they take care of the other \$50.00 or \$60.00 a month themselves
9 out of their pension. They are indigents to this degree sir
10 and in our case, and in most cases I would say the nursing
11 home operator checks with the doctor to see that he has been
12 paid. We consider it our duty to see that they get proper
13 medical care. We do not pay the doctor except in a very few
14 cases. I have in some cases paid the doctor because I realized
15 that he was not paid from any other source so I paid but
16 ordinarily we can arrange it through the Medical Welfare Plan.
17 If the patient has no funds of his own, he is eligible for
18 medical coverage, Welfare Plan coverage in the Province of
19 Ontario so it is not really a problem within our homes except
20 in a very few cases.

21 THE CHAIRMAN: Any further questions? Do you
22 have any further comments or statements you would care to make?

23 REVEREND GILL: No. It has been a pleasure to
24 be here sir.

25



1 attention, somebody has to arrange for payment of that and that
2 is not the responsibility of the Government.
3 REVEREND GILL: That is correct. It would not
4 be true to say that they are not involved in the financial aspect.
5 In many cases -- relating to my own 25 patients at the present
6 time, 12 of them are indigent. That is to say the insurance
7 does not pay approximately \$100.00 a month for their care and
8 they have to pay the other \$100.00 or \$150.00 a month themselves
9 out of their pocket. They are reluctant to do this because of
10 the cost, and in some cases I would say the nature
11 of the operation is such that the doctor has to see that he has been
12 paid. He considers it his duty to see that they get proper
13 medical care. We do not pay the doctor except in a very few
14 cases. I have in some cases paid the doctor because I realized
15 that we was not paid from any other source so I paid him.
16 ordinarily we can arrange to through the Medical Welfare Board.
17 If the patient has no funds of his own he is eligible for
18 medical coverage, while I am covered in the province of
19 Ontario as it is not really a problem within our home state
20 in a very few cases.
21 THE CHAIRMAN: Any further questions? Do you
22 have any further comments or statements you would care to make?
23 REVEREND GILL: No. It has been a pleasure to
24 be here sir.



1 THE CHAIRMAN: Thank you.

2

3 ---adjourned until 10:00 a.m. Wednesday morning January 8th
4 1964.

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25



1 THE CHAIRMAN: Thank you. Payment of that and that
2 is not the responsibility of the house.
3 ---adjourned until 10:00 a.m. Wednesday morning January 8th
4 by 1964. to say that the not indigent in the technical sense.
5 In many cases -- referring to my own 25 patients at the present
6 time, 12 of them are indigents. That is to say the remaining
7 some is paid approximately \$100.00 a month for their care and
8 they take care of the other \$20.00 or \$30.00 a month themselves
9 out of their pocket. They are indigents to this degree in
10 that in one sense, and in most cases I would say the nursing
11 home operator shares with the doctor to see that he has been
12 paid. We consider it our duty to see that they get proper
13 medical care. We do not pay the doctor except in a very few
14 cases. I have in some cases paid the doctor because I realized
15 that it was not paid from any other source so I paid out
16 ordinarily we can arrange it through the Medical Welfare Board.
17 If the patient has no funds of his own he is eligible for
18 medical coverage. Welfare plan coverage in the province of
19 Ontario so far as not really a problem with our home except
20 in a very few cases.
21 THE CHAIRMAN: Any further questions? No.
22 Now and I think comments on statements you would care to make
23 NOTHING MORE. No. It has been a pleasure to
24 be here with you. I have enjoyed the time very much.
25

